Total Mobility Medical Assessment Form

(We ask medical practitioners to provide this information before we contact applicants directly)

Applicant Details

Title _____ Surname _____

First Names _____ DOB _____

Address _____

_____

Phone (Home) _____ (Cell) _____

Email _____

To be eligible for the scheme, an applicant must have an impairment that prevents them from accessing public transport in a safe and dignified manner and that will last for longer than six months.

Please give brief details of the applicant's disability _____

_____

Are they able to:	**YES**	**NO**
Walk 500 metres unassisted	☐	☐
Stand up for 10 minutes unassisted	☐	☐
Step up and down from a bus	☐	☐
Handle money unassisted	☐	☐
Remain seated and travel securely on the bus	☐	☐
Travel on a bus without being confused or anxious	☐	☐
Travel on an accessible bus if it was available	☐	☐

Please list any mobility aids the applicant uses _____

It is a great help if a photo of the applicant can be emailed to us at the same time as the form.

Medical Practitioners Stamp

Practitioners Signature _____ Date _____

Please send this form to Aspire Canterbury
Email – totalmobility@aspirecanterbury.org.nz
Fax 03 379 5939