CENTRAL MASS SAFETY COUNCIL
186 West Boylston Street
West Boylston, MA 01583
Tel: 508-835-2333
Fax: 508-835-2869
www.centralmasafety.org

Welcome to the CMSC Adaptive Program!

You have received this packet because you are looking for an appointment for multi-step driving assessment/lessons.

Please **read** all attached forms, fill out completely (incomplete forms may get returned for more information), sign and send back mail or fax to the info on the header, or email to rhamburger@centralmasafety.org

1. Please send a picture of your license/permit

2. Please have your doctor fill out the enclosed form "**Occupational Therapy driving evaluation and treatment**" and have them fax it to us at 508-835-2869

3. *ONLY If you have ever worked with another driving school,* in the past 25 years, please fill out the attached "lessons only" form

4. *ONLY If you have a service animal and plan to bring your service animal to the evaluations and/or lessons.* Please read carefully and sign the Pet Policy waiver form

To be scheduled for an appointment, you **MUST RETURN ALL FORMS FULLY COMPLETED.**

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INTAKE FORM

Please complete each section **that applies to you.** All the requested information is important. Please **send a copy** of your license or permit with the completed form. Thank you.

1. CLIENT: REQUIRED FIELD- MUST BE FILLED OUT

*Name:

*DOB:

*Height (ft/inches):

*Address:

*City, State, Zip:

*Mailing Address (If Different):

*Phone:

*Email:

***Emergency Contact (name and phone number):**

2. REFERRAL/FUNDING SOURCE: REQUIRED FIELD - MUST BE FILLED OUT (circle yes or no)

***Are you private pay?** Yes No

*If **YES**, have fees (Evaluation plus travel costs) been explained to you? Yes No

*If **NO**, and you have a funding source such as MRC please make sure to fill out the below

***Funding Source Name:**

***Funding Source Email/Contact Info:**

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3. MEDICAL:

Do you have medical clearance to drive? Yes No

If no please explain:

***Diagnosis:**

***Date of diagnosis:**

***What are your Driving Concerns:**

***Who will supervise your driving?**

What vehicle(s) will you be driving?

***Will you be bringing a service animal to the evaluations/lessons:** Yes No

Do you have seizures: Yes No **Date of last seizure:**

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***Do you take daily medication (do not list medications):** Yes No

4. DRIVING HISTORY:

*** IS A RMV / DMV REQUIRED FIELD- MUST BE FILLED OUT**

***Do you have a License?** Yes No **Permit?** Yes No

***License or Permit #** _____
(Please print exactly how it is written include letters)

***License or Permit issue date:** _____ **expiration date:** _____

*Is your privilege to drive under suspension or revocation? Yes No

Do you currently use adaptive equipment to drive? Yes No

If yes, please describe and where did you acquire it:

If yes, do you have any problems using the equipment? Yes No

*Do you self-restrict your driving? Yes No

If yes, please describe it:

5. COGNITIVE ABILITIES:

*Do you have problems with any of the following? **(Please circle all that apply)**

Difficulty concentrating on task Memory difficulties

Explain(If applicable):

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6. PHYSICAL ABILITIES:

Do you have problems with any of the following? **(Please circle all that apply)**

Impaired function: left hand right hand

Impaired function: left arm right arm

Impaired function: left foot right foot

Impaired function: left leg right leg

Difficulty moving head: up down left right

Neuropathy: Yes No

Visual Difficulties: Yes No

Do you use any of the following:

Walker: Yes No Crutches: Yes No Cane: Yes No

Scooter: Yes No Make / Model:

Seated height: _____ inches

Manual wheelchair: Yes No Make / Model:

Seated height: _____ inches

Power wheelchair: Yes No Make / Model:

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Seated height: _____ inches

Can you independently transfer into / out of the wheelchair: Yes No

I have completed the Intake Form fully and to the best of my abilities. All the information provided is factual.

Client Signature: X_____

Please sign If client is a minor/if you are assisting he/she fill out the forms:

X_____

Date: _____