Central Mass Safety Council
186 West Boylston Street
West Boylston, MA 01583
Tel: 508-835-2333
Fax: 508-835-2869
centralmasafety.com

Welcome to the CMSC Adaptive Driving Program

You are receiving this intake packet because you have recently inquired about our Adaptive Driving Program. Let us start by gathering all the pertinent information and documents that we need to set up your initial clinical evaluation.

ADAPTIVE DRIVING PROGRAM INTAKE FORM

Please complete all the fields in this packet. A copy of your license/permit should also be remitted along with the doctor's order form that is included. Any missing documents or incomplete forms will delay scheduling

1. CLIENT INFORMATION

Full Name: _____

Date of Birth: _____

Height (ft/in): _____

Address: _____

City/State/Zip: _____

Mailing Address (if different):

Cell Phone#_____Home#_____

Email: _____

Emergency Contact Name: _____

Emergency Contact phone#_____

2. FUNDING SOURCE

Will you be a private pay client? ☐ Yes ☐ No

If you are a private pay client, have rates been explained? ☐ Yes ☐ No

If funded by an agency, please provide the agency name and contact info:

_____

3. HOW DID YOU HEAR ABOUT US?

_____

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4. MEDICAL INFORMATION

Do you have medical clearance to drive? ☐ Yes ☐ No

If no, please briefly explain: _____

Diagnosis: _____

Diagnosis date: _____/_____/_____

Do you have any driving concerns?

_____

Have you ever had a seizure? ☐ Yes ☐ No

If so, date of last seizure: _____/_____/_____

Do you take any daily medications (do not list names)? ☐ Yes ☐ No

Do you have a service animal? ☐ Yes ☐ No

5. DRIVING HISTORY

Are you a licensed driver? ☐ Yes ☐ No If not, do you have a Learner's Permit? ☐ Yes ☐ No

If your license is from out-of-state, how long have you lived in MA? _____Years_____Months

License/Permit Number: _____

Issue Date: _____/_____/_____ Expiration Date: _____/_____/_____

Are there any restrictions listed on your license? ☐ Yes ☐ No

If yes, what restrictions? _____

Is your license currently suspended or revoked? ☐ Yes ☐ No

Do you self-restrict when/ where you drive? ☐ Yes ☐ No

If yes, please explain? _____

What is the year/make/model of the vehicle you drive/or intend to drive? _____

_____

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Do you currently use any adaptive driving equipment? ☐ Yes ☐ No

If yes, describe your adaptive equipment

_____

Any difficulty using the equipment? ☐ Yes ☐ No

6. COGNITIVE ABILITIES

☐ Difficulty concentrating ☐ Memory difficulties

Please explain, if applicable: _____

7. PHYSICAL ABILITIES

☐ Left Hand impaired ☐ Right Hand impaired

☐ Left Arm impaired ☐ Right Arm impaired

☐ Left Foot impaired ☐ Right Foot impaired

☐ Left Leg impaired ☐ Right Leg impaired

Any head movement difficulty? ☐ Up ☐ Down ☐ Left ☐ Right

Neuropathy: ☐ Yes ☐ No Vision Difficulty: ☐ Yes ☐ No

Do you use any of the following mobility aids? Walker ☐Yes/☐ No Cane ☐ Yes/☐ No

Crutches ☐ Yes/☐ No Scooter ☐ Yes/☐ No

Manual Wheelchair ☐ Yes/☐ No Power Wheelchair ☐ Yes/☐ No

Manual Chair Make/Model: _____Height: _____in

Power Chair Make/Model: _____ Height: _____in

*Are you able to **independently** transfer to/from a sedan or small size SUV? ☐ Yes ☐ No

*Are you able to **independently** load/unload your mobility device (wheelchair/walker/other) into this same size vehicle? ☐ Yes ☐ No

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8. LANGUAGE ACCESS STATEMENT

To support safety and effective instruction, we ask participants to share their preferred spoken and written language. This helps ensure clear communication during evaluations and behind-the-wheel training. Language preference information is used only to support access to services and does not affect eligibility or participation.

Preferred language for:

- Spoken communication: _____
- Written materials: _____

9. CANCELLATION AND ARRIVAL POLICY

- No call/no show fee: $150.00 if not canceled within 24 hrs. prior to the appointment.
- Please try to arrive 15 minutes before your appointment to ensure everything is in order.

10. ATTENTION MASSABILITY CLIENTELE:

MassAbility clients acknowledge their evaluation information and subsequent driving lesson documentation may be shared with their MassAbility counselors upon request as part of third-party payment requirements.

11. SIGNATURES (Please sign and date this page to avoid delays in scheduling)

Client Signature: _____

Date: _____/_____/_____

Parent/Guardian Signature (if minor): _____

Date: _____/_____/_____

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DOCTOR ORDER – Occupational Therapy

Must be filled out by an MD, NP or PA

Office Name:	
Provider Name:	
Address:	
Phone:	
Fax:	
Patient Name:	
Patient DOB:	
Diagnosis: (mandatory to complete)	
Based on the client's current medications, are there any concerns or contraindications that may impact his or her ability to drive safely? ☐ **Yes** ☐ **No**	If yes, please briefly explain: _____ _____

Provider's signature: _____

Date: _____/_____/_____

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ENROLLMENT CHECKLIST

☐ Intake form- fully completed, signed and dated

☐ Doctor's Order- include the completed order with this packet or send it to your Dr. and have them fax it to us.

☐ Copy of your License/Permit or Mass ID attached

☐ Terms & Conditions waiver- signed and dated

Questions? Call/text (508) 835-2333 and choose **option 3** to leave a message for our Adaptive Department

or

email our Adaptive Coordinator, **Jennifer Bounville** @ jbounville@cmscautoschool.com

Thank you for choosing the CMSC Adaptive Driving Program!

PRE-DRIVER/DRIVER READINESS CHECKLIST

This checklist should be completed by the potential driver and an additional copy should be completed by a parent/guardian/caregiver. Responses should be to the best of your knowledge based on activities over the last 6 months. After each item, place a check in the box of the column that most appropriately describes the potential driver's abilities in that area.

Task	Independent	With Prompting	Not Able
Chooses appropriate clothing for the weather			
Initiates/manages time to complete a self-care routine to be ready for appointments, school, and work.			
Initiates cleaning/organization in the home			
Laundry (uses washer and dryer, puts clothes away)			
Completes assigned chores/homework on time			
Plans meals, can follow a recipe, and utilize several appliances simultaneously			
Operates stove, oven, and/or microwave safely			
Substitutes items for cooking			
Can verbalize how to respond in an emergency			
Can be home alone for several hours			
Asks for help if needed			
Resolves conflicts on their own and compromises			
Rides a bike, scooter, or other motorized equipment on streets with shared traffic			
Navigates as a pedestrian in unfamiliar places using a map or apps			
TOTALS			

Completed by: _____

Relationship to potential driver: _____

Date: _____

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