



Travel Training Referral Form

Section 1: Trainee Information			
Name:		Referral Date:	
Street Address:			
City, State, Zip code:			
Phone:		Email:	
Date of Birth:	Age:	Male <input type="checkbox"/>	Female <input type="checkbox"/>
Legal Guardian Information			
Name:		Phone:	
Emergency Contact Information			
Name:		Relationship:	
Address:			
City, State, Zip code:		Phone:	
Section 2:			
Training for: Specific Route <input type="checkbox"/> General Use <input type="checkbox"/>			
Destination:		Phone:	
Address:			
Contact person:		Phone:	
Hours of attendance:		Start date:	
Days of attendance:			
Does Trainee have a bus pass? yes <input type="checkbox"/> no <input type="checkbox"/>			
Does Trainee have a Discount Fare Card (DFC)? yes <input type="checkbox"/> no <input type="checkbox"/>			
If not, is trainee interested in applying for a DFC? yes <input type="checkbox"/> no <input type="checkbox"/>			
Section 3: Trainee's abilities and disabilities			
Memory Problem: Short term <input type="checkbox"/> Long term <input type="checkbox"/>		Communication difficulties <input type="checkbox"/>	
Social/behavioral problems <input type="checkbox"/>		Difficulties following instructions <input type="checkbox"/>	
Seizures: Uncontrolled <input type="checkbox"/> Controlled <input type="checkbox"/> N/A <input type="checkbox"/>			
Mobility Aids (check all that apply): None <input type="checkbox"/> Cane <input type="checkbox"/> Walker <input type="checkbox"/> Manual Wheelchair <input type="checkbox"/>			
Service Animal <input type="checkbox"/> Oxygen <input type="checkbox"/> Electric Wheelchair <input type="checkbox"/> Power Scooter <input type="checkbox"/> Other <input type="checkbox"/>			
Medications: yes <input type="checkbox"/> no <input type="checkbox"/> If yes, list medications used?			
Additional comments:			
Organization Making Referral			
Organization Name:			
Employee Name:		Phone:	