SONIA TANTI INDEPENDENT LIVING CENTRE (STILC)
APPLICATION FORM
(Wheelchair & seating assessments and driving assessments)

Section A

Date of referral: _____

Name & surname: _____

ID card no: _____

European Disability Card: _____

Male: ☐ Female: ☐ Other: ☐

Date of birth: _____

Tel no: _____

Mob no: _____

E-mail: _____

Address: _____

_____

_____

Please confirm that person referred is aware of this referral: Yes ☐ No ☐

Please fill in the below section and answer as applicable to help us understand your needs better and be able to provide you with a timely service. Not all sections may apply in your particular situation; fill in only those sections that apply to the referred person.

1. Does the person being referred have a degenerative disease?

Yes ☐ No ☐ Not applicable ☐

If yes, kindly provide more details and provide medical documentation with this application.

_____

_____

_____

2. Are there any major health issues?

Yes ☐ No ☐ Not applicable ☐

Is yes, kindly provide more details and medical documentation with this application.

_____

_____

_____

3. Are there any serious social and/ or familial issues making the need for this assessment urgent? (e.g. impact upon caring family members, carers, etc.)

Yes ☐ No ☐ Not applicable ☐

If yes, kindly provide details below.

_____

_____

_____

4. Is the referred person dependent on this assessment to continue with community life? (e.g. school, employment, driving etc.)

Yes ☐ No ☐ Not applicable ☐

If yes, please provide details.

_____

_____

_____

5. Are there any serious safety concerns for which this assessment is required?

Yes ☐ No ☐ Not applicable ☐

If yes, kindly provide details below.

_____

_____

_____

Type of impairment (Tick where applicable)

Physical	☐
Intellectual	☐
Impaired vision	☐
Psychological	☐
Impaired hearing	☐

Services required (Tick where applicable)

Driving assessment	☐
Wheelchair and seating assessment	☐
Driving lessons on modified car	☐
Mobility scooter assessment	☐
Car Inspection	☐

Specify disability and medical conditions

_____

_____

_____

Reason for referral

(If you so prefer, this section can be filled in by a Doctor, Occupational Therapist or Physiotherapist). In case of self-referrals, please fill in this section yourself.

Please provide a clear description of the reason for referral.

_____

_____

_____

_____

Section B

In case this referral is being made by a Doctor, Occupational Therapist or Physiotherapist, kindly attach a medical note (e.g. hospital case summary, therapist's report/ assessment, medical report, etc.) about the need for this referral if you have such documentation.

Fill in if applicable.

Name & surname of referrer: _____

Position: _____

Organisation: _____

Contact number: _____

E-mail address: _____

Section C

This section has to be filled in for Driving Assessment Referrals only.

I, _____ (name and surname), holder of identity card number _____, authorise Aġenzija Sapport to provide information about the progress of this application to Transport Malta.

_____

Signature

Kindly return form to Aġenzija Sapport on postal address Sonia Tanti Independent Living Centre (STILC) Ċentru Pastorali Qalb ta' Gesu, Bizantini Street, Qrendi, or via email on stilc.sapport@gov.mt or through e-form on www.sapport.gov.mt