AĠENZIJA SAPPORT

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

The scope of this referral is to assess the applicant's physical and cognitive ability to drive a vehicle and to support the applicant by recommending aids and adaptations that may be required.

Section A

Date of referral: ___________________________________

Details of the Person Referred

Name & surname: ___________________________________

ID card no: ___________________________________

SID card no: ___________________________________

Male: ☐ Female: ☐ Other: ☐

Date of birth: ___________________________________

Tel no: ___________________________________

Mob no: ___________________________________

E-mail: ____

Address: ____

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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.

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2. Are there any major health issues?

Yes ☐ No ☐ Not applicable ☐

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

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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.

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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.

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

Yes ☐ No ☐ Not applicable ☐

If yes, kindly provide details below.

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Type of impairment (Tick where applicable)		**Services required (Tick where applicable)**	
Physical	☐	Driving assessment	☐
Intellectual	☐	Wheelchair and seating assessment	☐
Impaired vision	☐	Driving lessons on modified car	☐
Psychological	☐	Mobility scooter assessment	☐
Impaired hearing	☐	Car Inspection	☐

Specify disability and medical conditions

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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.

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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.

Details of the Referrer (If applicable)

Name & Surname: ____________________________________

Position: ____________________________________

Organisation: ____________________________________

Contact number: ____________________________________

E-mail address: ____________________________________

Section C

I __________________________________, holder of ID card number (______________________),

give my consent to being referred to Aġenzija Sapport for the service/s indicated above in this form. I understand that the Agency will use the above information for the provision of such service/s and that I will be contacted by the same Agency to discuss the way forward. Should I refuse the service, all the personal information in this document will be deleted.

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Signature

Kindly return form to Aġenzija Sapport on postal address STILC, Ċentru Pastorali Qalb ta' Ġesù, Biżantini Street, Qrendi, or via email on stilc.sapport@gov.mt or through e-form on www.sapport.gov.mt.