



PLEASE CHECK THE APPROPRIATE BOX

NEW ADMISSION REQUEST

REQUEST FOR REVIEW

Admission

Escort

FOR COMMITTEE USE ONLY

File number

Request received on

<input type="text"/>	<input type="text"/>	<input type="text"/>
Y	M	D

HOW TO FILL OUT THE FORM?

The Admissions Committee must have all the relevant information in order to determine the admissibility of the person requesting transportation (referred to as **the applicant**), as well as the appropriate type of transportation and escort requirements.

Any incomplete or illegible form will be returned to the applicant, which will further delay request processing. Any false declarations could result in admissions being refused or revoked.

Information provided will remain confidential and will only be used by the Admissions Committee. Only information needed to ensure the comfort and safety of admitted applicants will be provided to paratransit carriers.

PART 1 – GENERAL INFORMATION

This section must be filled out by applicants, or by their legal guardian, or by any other designated person if applicants cannot do so themselves. Please provide detailed answers to all questions.

Applicants, or their legal guardian, must sign the admissions form on page 3.

PART 2 – DIAGNOSIS

This section deals with the diagnoses for each type of disability, and can only be filled out by a member of the medical professions listed on each diagnosis sheet. If applicants have more than one disability, all corresponding diagnosis sheets must be filled out.

PART 3 – BEHAVIOURAL PROBLEMS AND EPILEPSY

The safety of other paratransit users is a major concern. It is therefore crucial that we have all the relevant information regarding an applicant’s behavioural problems, which may be manifest during transportation.

If applicant is epileptic, please provide required information on page 12.

OTHER DOCUMENTS REQUIRED FOR ADMISSIONS REQUEST

Your admissions request must include:

- A passport-size picture
- Proof of birth (photocopy of birth certificate or health insurance card)

Applicants may also enclose any additional information or report relating to their admissibility or paratransit transportation requirements.

SEND DOCUMENTS TO:

STM Paratransit Service
Admissions Committee
3111 Jarry St. East
Montreal, Quebec
H1Z 2C2

AFTER REVIEWING ALL DOCUMENTS, THE ADMISSIONS COMMITTEE WILL DETERMINE ADMISSIBILITY AND INFORM APPLICANTS OF ITS DECISION IN WRITING.

PART 1 – GENERAL INFORMATION

IMPORTANT

APPLICANTS MUST INCLUDE A PHOTOCOPY OF THEIR BIRTH CERTIFICATE OR HEALTH INSURANCE CARD AND A PASSPORT-SIZE PICTURE, OTHERWISE THEIR ADMISSIONS REQUEST FORM WILL NOT BE SUBMITTED TO THE ADMISSIONS COMMITTEE.

IN WHICH LANGUAGE DO YOU WISH TO RECEIVE FURTHER CORRESPONDANCE? French English

This section must be filled out by applicants, or by their legal guardian, or by any other designated person if applicants cannot do so themselves. Please provide detailed answers to all questions.

1 – Applicant identification

• PLEASE PRINT •

Name		First Name							
Home address			Entrance code (if any)						
Apt.	City	Postal code	Telephone ()						
Mailing address (if different)			Apt.						
City		Postal code							
Name of residence or institution (if applicable)									
Gender		Date of birth							
Male <input type="checkbox"/>	Female <input type="checkbox"/>	Weight	Height						
			<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> </tr> <tr> <td align="center">Y</td> <td align="center">M</td> <td align="center">D</td> </tr> </table>				Y	M	D
Y	M	D							

2 – What is your primary disability?

3 – Do you have other disabilities?

No Yes Specify _____

4 – Of the following limitations, please check those which make the use of paratransit services necessary, and indicate if they are permanent, seasonal, intermittent or temporary.

	Permanent	Seasonal	Intermittent	Temporary	Approx. duration
Difficulty walking					
Lack of stamina / endurance					
Visual impairment					
Memory lapses					
Spatial orientation					
Behavioural problems					
Language or elocution difficulties					
Hearing problems or deafness					

Specify _____

5 – Which mobility aids do you regularly use to assist you outside?

- | | |
|--|--|
| <input type="checkbox"/> Personal aide/escort
<input type="checkbox"/> Walker folding <input type="checkbox"/> non-folding <input type="checkbox"/>
<input type="checkbox"/> Long detection cane
<input type="checkbox"/> White support cane
<input type="checkbox"/> Crutches
<input type="checkbox"/> Guide dog
<input type="checkbox"/> Service dog
<input type="checkbox"/> Cane, specify type _____
<input type="checkbox"/> Other devices used to assist mobility, specify _____ | <input type="checkbox"/> Manual wheelchair* (folding)
Specify model _____
<input type="checkbox"/> Motorized wheelchair*
Specify model _____
<input type="checkbox"/> Three-wheel/four-wheel scooter*
Specify model _____
<input type="checkbox"/> Other type of wheelchair, specify _____
<input type="checkbox"/> Child stroller, specify model _____ |
|--|--|

If mobility aids are only used occasionally, indicate under which circumstances

** For safety reasons, all wheelchairs (manual or motorized) must come equipped with four anchoring devices for secure attachment to paratransit vehicle floor.*

6 — Do you use regular public transit services?

- Bus** No
 Yes, without an escort
 Yes, always with an escort
 Yes, occasionally with an escort

- Métro** No
 Yes, without an escort
 Yes, always with an escort
 Yes, occasionally with an escort

If you answered **No**, specify reasons.

7 — Do you have children under the age of 14 for whom you are responsible?

No Yes

Name	First name	Date of birth
_____	_____	____/____/____
_____	_____	____/____/____
_____	_____	____/____/____

8 — If you were admitted to Paratransit services, would you require any special assistance aboard the vehicle?

No Yes Specify _____

9 — Are you able to communicate verbally?

No Yes Explain _____

Do you use a device to help you communicate?

Yes No Fax Teletype Internet
 Other device; specify _____

10 — If this section was not filled out by applicant, please identify person who did.

Name	First name
Home telephone number	Office telephone number Ext.
Relation to applicant	Name of institution (if applicable)

11 — Emergency contact

Name	First name
Home telephone number	Office telephone number Ext.
Cellphone/Pager	Relation to applicant
Name of institution (if applicable)	

AUTHORIZATION (signature required)

I hereby certify that the information provided is accurate. I authorize other persons acting on my behalf, as a personal aide or healthcare worker, to provide the STM, upon request, with all information pertaining to this admissions request to Paratransit services or any other information the STM may deem necessary to ensure my comfort and safety, as well as those of other paratransit users. Moreover, the STM is hereby authorized to provide any required personal information about me to other paratransit carriers who may provide transportation within the Greater Metropolitan Montreal area, and to the Agence métropolitaine de transport (AMT), as the agency responsible for overseeing the integration project for paratransit services.

 Signature of applicant or legal representative

Date

Y	M	D
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PART 2 – VISUAL IMPAIRMENT DIAGNOSIS

This section must be completed by an optometrist, an ophthalmologist or by a professional in a eye care centre, based on an established diagnosis.

If applicant has more than one impairment, the other sections relating to the various impairments must also be completed as needed (intellectual, psychiatric, motor or organic).

1 – Medical diagnosis or problem

2 – Visual acuity: corrected far-sighted vision (metric)

Field of vision RE _____ LE _____ OU _____
Less than 20° RE _____ LE _____ More than 20° RE _____ LE _____

3 – Origins of impairment

Congenital defect Accident (Date)

Y	M	D

 Disease (Date)

Y	M	D

4 – Does applicant experience difficulties with spatial orientation or when coping with situations that could jeopardize his/her safety or the safety of applicant’s children ?

No Yes, at all times
 Yes, at certain times and under certain circumstances. Explain. _____

5 – Have the applicant’s impairments lead to any limitations regarding mobility?

No Yes Explain. _____

6 – Is applicant epileptic? No Yes

If you checked Yes, please fill out section about EPILEPSY on page 12.

7 – Have applicant’s impairments lead to behavioural problems?

No Yes
If you checked Yes, please fill out section about BEHAVIOURAL PROBLEMS on page 12.

8 – In light of applicant’s condition, is full or partial recovery anticipated?

No Yes When? _____
Explain _____

9 – Has applicant received any training to improve mobility or spatial orientation?

If Yes, specify from whom _____ Year _____ Duration _____

Results

If no, explain why? _____

Recommended training program

Conditional to (age, other related problem)

10 — Please indicate any other information you feel should be brought to the attention of the Admissions Committee. Attach documents as needed.

11 — Diagnosis made by:

I hereby certify that the information provided is accurate. I understand that any false declaration could result in paratransit services being refused or revoked, if applicant is already admitted.

How long have you been treating this person? _____

**Practitioner's stamp
or seal or medical
license number**



Name	Medical Profession			
Mandatory signature				
Telephone number				
Examination date	<table border="1"> <tr> <td>Y</td> <td>M</td> <td>D</td> </tr> </table>	Y	M	D
Y	M	D		
Form completed on	<table border="1"> <tr> <td>Y</td> <td>M</td> <td>D</td> </tr> </table>	Y	M	D
Y	M	D		

If this section was filled out by someone other than diagnostician:

Name	Medical Profession			
Mandatory signature				
Telephone number				
Examination date	<table border="1"> <tr> <td>Y</td> <td>M</td> <td>D</td> </tr> </table>	Y	M	D
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PART 2 – DIAGNOSIS OF INTELLECTUAL DISABILITY

This part must be completed by a psychiatrist, psychologist, physician, or by a professional from a rehabilitation centre for the intellectually disabled, based on an existing diagnosis.

If applicant has more than one impairment, the other sections relating to the various impairments must also be completed as needed (visual, psychiatric, motor or organic).

1 – Medical diagnosis or problem

2 – Degree of impairment

Related difficulties

Problems with mobility No Yes Explain _____

Problems with temporal awareness No Yes Explain _____

Problems with spatial orientation No Yes Explain _____

Problems relating to personal safety No Yes Explain _____

Behavioural problems No Yes

*If you checked **Yes** for **BEHAVIOURAL PROBLEMS**, please fill out related section on page 12.*

3 – Is applicant epileptic? Yes No

*If you checked **Yes**, please fill out section about **EPILEPSY** on page 12.*

4 – Can applicant handle basic abilities, such as getting dressed on their own and eating unassisted?

Yes No

Explain

5 – Has applicant received any training toward using regular transit system?

If yes, specify from whom _____ Year _____ Duration _____

Results

(Attach training report, if applicable)

If no, explain why?

Recommended training program

Beginning

Y	M	D

Probable duration

Conditional to *(age, related problem)*

6 – Applicant's ability to travel on their own

Does not apply Yes, under certain circumstances

If yes, specify

7 — Please indicate any other information you feel should be brought to the attention of the Admissions Committee. Attach documents as needed.

8 — Diagnosis made by:

I hereby certify that the information provided is accurate. I understand that any false declaration could result in paratransit services being refused or revoked, if applicant is already admitted.

How long have you been treating this person? _____

**Practitioner's stamp
or seal or medical
license number**



Name	Medical Profession			
Mandatory signature				
Telephone number				
Examination date	<table border="1"> <tr> <td>Y</td> <td>M</td> <td>D</td> </tr> </table>	Y	M	D
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Y	M	D		

PART 2 – DIAGNOSIS OF PSYCHIATRIC DISABILITY

This section must be completed by a psychiatrist, psychologist, physician, or by a professional from a psychiatric hospital or facility, based on an existing diagnosis.

If applicant has more than one disability, the other sections relating to the various disabilities must also be completed as needed (visual, intellectual, motor or organic).

1 – Medical diagnosis or problem

2 – Since when?

3 – This disability manifests itself:

Continuously Intermittently Specify _____

Are manifestations controlled by medication? Yes No Specify _____

4 – Has the applicant’s disability lead to any limitations regarding mobility?

No Yes Explain _____

Related difficulties

Problems with temporal awareness No Yes Explain _____

Problems with spatial orientation No Yes Explain _____

Problems relating to personal safety No Yes Explain _____

Behavioural problems No Yes

*If you checked **Yes** for **BEHAVIOURAL PROBLEMS**, please fill out related section on page 12.*

5 – Is applicant epileptic? Yes No

*If you checked **Yes**, please fill out section about **EPILEPSY** on page 12.*

6 – Is recovery of functional status anticipated?

No Yes When? _____

Explain _____

7 – Has applicant followed a familiarization program (treatment or behavioural therapy) in order to use regular transit system?

If yes, supervised by _____

Indicate where _____ Year _____ Duration _____

Results

(Attach training report, if applicable)

If not, explain why?

Recommended training program

Beginning _____ Probable duration _____

Y	M	D
---	---	---

Conditional to *(age, related problem)*

8 – Applicant’s ability to travel on their own

Does not apply Yes, under certain circumstances

If yes, specify

9 — Please indicate any other information you feel should be brought to the attention of the Admissions Committee. Attach documents as needed.

10 — Diagnosis made by:

I hereby certify that the information provided is accurate. I understand that any false declaration could result in paratransit services being refused or revoked, if applicant is already admitted.

How long have you been treating this person? _____

**Practitioner's stamp
or seal or medical
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PART 2 – DIAGNOSIS OF MOTOR OR ORGANIC DISABILITY

If applicant has a cardiac deficiency, this section must be completed by a cardiologist.
If applicant has a respiratory deficiency, this section must be completed by a pneumologist.
If applicant is epileptic, this section must be completed by a neurologist. In all other cases,
it must be filled out by a physician or by a health care professional
in a rehabilitation centre, based on an existing diagnosis.

If applicant has more than one disability, the other sections relating to the various disabilities must also be completed accordingly (visual, psychiatric, or intellectual).

1 – Medical diagnosis or problem

2 – Since when?

3 – Specify the medical classification of diagnosis at the functional level

- Cardiac Class / IV Respiratory Class / V
 Parkinson Phase / V Other _____

4 – Is applicant epileptic? No Yes

*If you checked **Yes**, please fill out section about **EPILEPSY** on page 12.*

5 – Have applicant's disabilities lead to behavioural problems?

- No Yes

*If you checked **Yes** for **BEHAVIOURAL PROBLEMS**, please fill out related section on page 12.*

6 – Is applicant able to walk outside?

- No
 Yes

- Time required to cover a distance of 400 metres _____ minutes.
- Maximum distance walked _____ metres
- Time required to cover that distance _____ minutes
- Mobility aids needed _____

7 – Is applicant able to climb up (with support) or climb down (without support) a 35 cm step?

- Yes No, unable at any time to climb with support or climb down without support

Explain _____

8 – Is applicant able to transfer from wheelchair to car seat unassisted?

- Yes No, explain _____

9 – Is applicant able to sit in either front or back seat of taxi vehicle?

- Yes No, explain _____

10 – Is recovery of functional status anticipated?

- Yes No, explain _____

11 – Does applicant use one or more mobility aid devices on a regular basis?

- Yes No, explain _____

Orthosis Prosthesis Specify _____

12 — Please indicate any other information you feel should be brought to the attention of the Admissions Committee. Attach documents as needed.

13 — Diagnosis made by:

I hereby certify that the information provided is accurate. I understand that any false declaration could result in paratransit services being refused or revoked, if applicant is already admitted.

How long have you been treating this person? _____

**Practitioner's stamp
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Behavioural problems

Describe the nature of applicant’s behavioural problems and how they manifest themselves:

During transportation, is applicant able to control certain behavioural reactions, such as impulsiveness, aggressiveness or self-mutilation, that could jeopardize their own safety or the safety of others?

- Yes No

If **No**, are these behavioural reactions manifest

- At all times, specify _____

- Intermittently, specify _____

- In certain situations, specify _____

Epilepsy

If applicant is epileptic:

Is applicant’s condition controlled by medication? Yes No Partially

- If medication is currently used on trial basis, specify _____

- If seizures are not completely controlled by any medication, specify _____

Describe the nature of seizures (by type and manifestation):

If applicant has severe seizures, including loss of consciousness or convulsions, indicate how many times a week they occur on average.

Side effects to medication likely to occur during transportation, if applicable:

Explain how and why applicant’s safety is jeopardized during transportation:
