



Part 3 – Functional assessment of a person with a motor or organic impairment

This part must be completed by an occupational therapist, a physiotherapist, a psychiatrist or a rehabilitation therapist.

The information provided is confidential and for the sole use of the eligibility committee.

PLEASE PRINT

Identification of person

Family name	Given name
-------------	------------

Address of residence	N ^b	Street	Apt n ^b	Municipality	Postal Code
----------------------	----------------	--------	--------------------	--------------	-------------

1. Is the person able to walk 400 meters on smooth, level ground without help ?

- Yes
- No, give the distance in meters the person can walk, the time this takes and his physical condition after walking this distance (pain, etc.) ?

2. Is the person capable of climbing a step 35 cm high, with support ?

- Yes
- No, if not, specify _____

3. Is this person capable of descending a step 35 cm high, without support ?

- Yes
- No, if not, specify _____

4. This impairment is :

- Permanent Temporary, with a probable duration of _____

N.B. The content of this form is prescribed by the ministère des Transports du Québec

5. Is the person capable of using regular public transport for all trips without becoming extremely fatigued ?

- Yes
 No, explain _____

If not, specify the type of assessment this person underwent. If no assessment was made, give the reason _____

6. The person is capable of communicating :

- Verbally By symbols
 Through the manual method Other, specify _____

7. Is this person now receiving rehabilitation services, or will he be receiving such services ?

- Yes
Supervised by _____ Beginning date _____ Year / Month
 No, why _____

8. Has this person ever received rehabilitation services ?

- Year / Month
 Yes, ended on _____ / _____
 No

9. If this person were declared eligible for paratransit, would his physical limitations require that he be always accompanied in the vehicle?

- No
 Yes, state why ? _____

10. This part was completed by :

Name _____ Function _____ Tel. no. : _____

Signature of authorized professional _____ Date _____ Year / Month / Day

N.B. The content of this form is prescribed by the ministère des Transports du Québec