



# Spokane Transit

\_\_\_\_\_  
Trainer

\_\_\_\_\_  
Date

## REFERRAL FOR MOBILITY TRAINING

DATE OF REFERRAL: \_\_\_\_\_

TRAINEE NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

APT. COMPLEX OR CARE HOME: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_ ZIP: \_\_\_\_\_

MALE: \_\_\_\_\_ FEMALE: \_\_\_\_\_ AGE: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

LEGAL GUARDIAN (if applicable) \_\_\_\_\_ PHONE: (H) \_\_\_\_\_

\_\_\_\_\_ Public Conservator (W) \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ PHONE: (H) \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_ (W) \_\_\_\_\_

IS TRAINING FOR: SPECIFIC ROUTE: \_\_\_\_\_ GENERAL USE: \_\_\_\_\_

DESTINATION: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CONTACT PERSON: \_\_\_\_\_ PHONE: \_\_\_\_\_

HOURS OF ATTENDANCE: \_\_\_\_\_ START DATE: \_\_\_\_\_

DAYS OF ATTENDANCE: \_\_\_\_\_

ORGANIZATION MAKING REFERRAL: \_\_\_\_\_

PERSON MAKING REFERRAL \_\_\_\_\_ PHONE: \_\_\_\_\_ EXT. \_\_\_\_\_

Please describe trainee's abilities and disabilities, include any medical considerations, social/behavioral problems; communication difficulties and cognitive abilities.

PLEASE CHECK THE BOX IF YOU ARE A CURRENT PARATRANSIT USER: