Verification of Disability

This part of the form is to be completed by a registered health professional. Please complete this form in clear handwriting or electronically.

Patient's Full Name	

What disability does the individual have?

Will their disability change over time?

☐ **Yes** ☐ **No**

If **YES**, please provide details:

In your opinion, how far can the individual walk, with or without aids? *(Please tick one)*

☐ **Cannot get out of the house** ☐ **Can only reach the letterbox** ☐ **Up to 50 metres**

☐ **Up to 100 metres** ☐ **Up to 200 metres** ☐ **Up to 500 metres**

☐ **Over 500 metres** ☐ **Fully mobile**

Please circle the number that most closely matches your assessment of the individual's need for assistance:

NOT ESSENTIAL 1 2 3 4 5 6 7 8 9 10 **ESSENTIAL**

How does their disability impact on their ability to participate in their community?

Health Professional Details

Name	
Occupation	
Registration number	
Postal address	
Phone number	
Date	
Signature	