# 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 |  |