DALLAS AREA RAPID TRANSIT
ADA PARATRANSIT ELIGIBILITY

Seizure and Epilepsy Verification Form

Name: _____ Date: _____

Date of Birth: _____

This certification form will be used to determine your eligibility for Dallas Area Rapid Transit Paratransit Services. This form is to be completed and signed by your physician. Answer every question. Incomplete forms will be returned.

1. Has patient been diagnosed with a seizure disorder?

   Yes___ No____ Date of Onset_____

2. Has patient been diagnosed with epilepsy?

   Yes ___ No ____ Date of Onset_____

3. Date of last seizure_____

4. Which of the following types of seizures does patient have? Please circle all that apply.

   Absence Seizures Petit Mal Grand Mal
   Complex Partial Simple Partial Seizures Psychomotor Seizures
   Tonic Clonic Other_____

5. Are seizures controlled by medications? Yes___ No___
   If no, please explain: _____
   _____
   _____
   _____

6. Does patient have any warning signs before seizures*?* Yes___ No___
   If yes, please explain: _____
   _____
   _____

7. What triggers seizures? _____
   _____
   _____

8. When was last reported seizure? _____
   _____
   _____

9. Has patient required immediate medical attention after a seizure? Yes____No___
   If yes, please explain: _____
   _____
   _____
   _____

10. Does patient experience confusion or disorientation following a seizure? Yes ___ No__
    If yes, please explain: _____
    _____
    _____
    _____

I verify that the information stated above is accurate to the best of my knowledge.

_____	_____	_____
Physician Name Printed	Physician Signature	License # - State