ATTACHMENT D

Applicant with Seizure Disorders

Name of Applicant:_____

Name of Licensed Physician:_____

Date Completed:_____

1. In what capacity do you know the applicant?

_____

_____

2. How long have you known or worked with the applicant?

_____

_____

3. When did you last see the applicant?_____

4. Please describe what the applicant experiences during and after a seizure._____

_____

_____

5. How often do seizures occur?

_____

_____

6. What is the prognosis?

_____

_____

7. Are the seizures preceded by an aura?

☐ Yes ☐ No ☐ Sometimes

8. If YES or SOMETIMES, does the applicant usually have time to prepare and make him or herself as safe as possible?

Comments:_____

9. Are there certain things that will trigger the applicants' seizures?

☐ Yes ☐ No ☐ NA

Comments:_____

10. If YES, please describe these triggers.

☐ NA

11. Please describe the applicants' ability to travel alone in the community. When and where can he/she safely travel?

12. What advice or limitations on traveling alone in the community have been communicated to the applicant?

_____

_____

_____

_____

13. Is the applicant permitted to drive?

☐ Yes ☐ No

Comments:_____

_____

_____

14. Is the applicant taking any medication(s) prescribed by you or another professional?

☐ Yes ☐ No

Comments:_____

_____

_____

15. If YES, please list the type, frequency, dose, and any comments about how the medication(s) may complicate the individual's independent mobility in the community.

Medication Type	Dosage	Effect on Functional Ability (if any)

16. If the applicant takes his/her medication compliantly, will he/she be able to travel independently in the community.

☐ Yes ☐ No ☐ NA

Comments:_____

_____

_____

17. Do you deem the applicant to be compliant in taking prescribed medication?

☐ Yes ☐ No ☐ NA

Comments:_____

_____

_____

18. Is there anything about the use of medication that would complicate the individual's use of public transportation?

☐ Yes ☐ No ☐ NA

If YES, please explain._____

_____

_____

19. Has the applicant functional ability decreased *temporarily* due to adjustment to medication?

☐ Yes ☐ No ☐ NA

20. If YES, please explain, and note the expected duration of the decrease in functional ability.

_____

_____

_____

21. Comments about the applicants' typical activities and current travel destinations.

_____

_____

_____

PLACE LICENSE PHYSICIAN OFFICIAL STAMP BELOW:

Signature:_____ Date:_____

Print Name and Title:_____

Current Guam Medical License No.:_____

Business Address:_____

Mailing Address:_____

Telephone No.:_____ Fax:_____