

To the Referring Counselor: Please ensure that the Consumer has had an [Initial Visual Examination](#) for the KY Bioptic Driving Program completed, and that this is uploaded into the **Bioptic Referral Folder** in CMS for review prior to completing this application.

1. Consumer Information

Name			
Case Number	Consumer Type	Date of Birth (MM/DD/YYYY)	
Address			
City		State	Zip Code
Cell Phone	Home Phone	Email Address	
Emergency Contact Name		Emergency Contact Phone Number	

2. Driving History

Current Driver's License?	If yes, what state?
Previously Licensed?	If yes, what state?
Has the Consumer previously participated in a Driver Training Program?	
<i>(If yes, please describe where the program was located and provide the estimated start and completion dates of the program)</i>	

Does the consumer have any barriers to purchasing or obtaining access to a car once they receive their driver's license?

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3. Disability Information

Does the consumer have a secondary disability which impacts their ability to get in and out of a vehicle safely?

(If yes, please explain)

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Does the consumer have a hearing impairment?

If yes, please explain and describe the devices/accommodations needed (i.e., hearing aid(s), amplification, interpreter, etc.)

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Does the consumer have a mental health diagnosis?

(If yes, please indicate where to locate supporting documentation in CMS, including folder and document title.)

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Has the consumer received counseling for diagnosis or adjustment?

(If yes, please indicate where to locate supporting documentation in CMS, including folder and document title.)

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Do you have any safety concerns regarding the Consumer's past or current behavior?

(If yes, please describe)

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4. Medical Information

Is the consumer diabetic?	If yes, are they insulin dependent?
Does the consumer take any medications? <i>(If yes, please send complete medication list with application)</i>	
Please explain any other current or past medical conditions that bioptic program staff need to be aware of	