Ozark Regional Transit
ADA Paratransit Eligibility Application
Epilepsy & Seizure Disorder Supplemental Form
Updated 10/09/2017

Date Received by ORT: _____________

If you need assistance completing this application, please call the ORT Call Center at (479)756-5901 Ext. 2176

Personal Contact Information

______________________________________________________________________________
Name                                      Phone                                      Date of Birth
______________________________________________________________________________

Person assisting with application           Phone                                      Relationship

Questions Pertaining to Your Seizures

1. Have you ever been diagnosed with Epilepsy or another seizure disorder?
   ___ Yes       ___ No

   Please explain:
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________

2. Which of the following types of seizures do you have?
   ___ Absence Seizures              ___ Petit Mal Seizures
   ___ Complex Partial Seizures      ___ Simple Partial Seizures
   ___ Psychomotor Seizures          ___ Tonic Clonic Seizures
   ___ Grand Mal Seizures            ___ Other – Specify ____________________________
3. Do you have any warning signs before you have a seizure? (Example: aura)

___ Yes     ___ No

Please explain:

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

4. Do any of the following triggers cause your seizures?

___ Stress     ___ Anxiety
___ Flashing Light        ___ Loud Noise
___ Heat             ___ Fatigue
___ Dehydration       ___ Not taking medication
___ Other - Specify __________________________

5. How often do you have seizures?

___ Daily           Frequency ______
___ Weekly          Frequency ______
___ Monthly         Frequency ______
___ Yearly          Frequency ______

6. How long do your seizures usually last?

____________________________________________________________________________
____________________________________________________________________________

7. Are you currently on prescription medication to help control seizures?

___ Yes     ___ No

Please explain:

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

8. What behaviors do you exhibit during your seizures?

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
9. Do you demonstrate any of the following after your seizures?

___ Confusion  
___ Physical Weakness  
___ Disorientation  
___ Agitation or Irritability  
___ Sleepiness  
___ Anxiety  
___ Impaired Awareness  
___ Other ______________________________

10. Does your Epilepsy or seizure disorder interfere with any of the following major life activities?

___ Self Care  
___ Mobility  
___ Play  
___ Independent Living  
___ Work  
___ Communication  
___ Leisure Activities

11. Have you ever required immediate medical attention after a seizure?

___ Yes  ___ No

Please explain:
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________