



# Neighbors Driving Neighbors

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## Rider Information

AR updated \_\_\_\_/\_\_\_\_/\_\_\_\_  
Google contact done ☐

Date of initial contact \_\_\_\_\_

First name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Email address: \_\_\_\_\_

How do you currently get to appointments, shopping etc.? \_\_\_\_\_

Do you need assistance getting from the house to the car? \_\_\_\_ yes \_\_\_\_ no

Do you have any medical conditions or handicaps that we should be aware of?

\_\_\_\_ yes \_\_\_\_ no. If yes, please describe \_\_\_\_\_

Do you have any problems with hearing or vision? \_\_\_\_ yes \_\_\_\_ no. If yes, please

describe: \_\_\_\_\_

Do you use a \_\_\_\_\_ walker \_\_\_\_\_ wheelchair \_\_\_\_\_ cane \_\_\_\_\_ oxygen or any other adaptive /assistive device \_\_\_\_\_ If yes, please describe:

How many times have you fallen in the last 12 months? \_\_\_\_\_

Will you have a cellphone with you? \_\_\_\_ yes \_\_\_\_ no. Number: \_\_\_\_\_

Do you live alone? \_\_\_\_ yes \_\_\_\_ no

If yes, do you have a caregiver? \_\_\_\_ yes \_\_\_\_ no. If yes, provide info below:

Caregiver Name: \_\_\_\_\_ Caregiver phone: \_\_\_\_\_

If no, who else is in your household? \_\_\_\_\_

Who should we contact if an emergency occurs while we are driving you?

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship: \_\_\_\_\_

Who is your primary care provider?

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Do you smoke? \_\_\_\_ yes \_\_\_\_ no

Are you allergic to pet hair or fragrances? \_\_\_\_ yes \_\_\_\_ no, If yes, circle which.

How did you learn about our program? \_\_\_\_\_

Do you consider yourself low-income? \_\_\_\_ yes \_\_\_\_ no

Do you have a handicapped placard from the DMV? \_\_\_\_ yes \_\_\_\_ no  
If no, if you need one, are you willing to apply for one? \_\_\_\_ yes \_\_\_\_ no

Directions to/description of your home: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Interviewer Notes

Interviewer \_\_\_\_\_ Date \_\_\_\_\_