# Companion Free Travel Pass

You should only complete this form if you are in receipt of a standard Free Travel Pass and under 70 years.
If you are not in receipt of a standard Free Travel Pass then you should complete form FT1.
Please see information booklet **SW40** for more information.

## PART 1 — Your own details

**Please state:** ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Other _____ **Please specify**

1. **Your surname:**
2. **Your first names (s):**
3. **Your address:**
4. **Your date of birth:**
5. **Your free travel pass number:**
6. **Your Personal Public Services Number (PPS No.):**
7. **Your Telephone Number** if any**:** Landline / Mobile

## PART 2 — Authorisation for release of medical information - to be completed by YOU

Please sign the authorisation below which will allow your Doctor to supply to this Department the medical information required in support of your application for a companion free travel pass. Your Doctor should then complete Part 3 of this application form.
The medical information provided will be reviewed by one of the Department's Medical Assessors to determine your eligibility for a companion free travel pass.

**I authorise my Doctor to provide the Department of Social and Family Affairs with medical information, now or in the future, which may be required in support of my application for a Companion Free Travel Pass.**

| YOUR Signature Or Mark | DATE |
|---|---|

**(NOT Block Letters)**

**If the applicant is not able to sign, his/her mark should be made and witnessed. The witness should sign below.**

| Signature Of Witness | DATE |
|---|---|

Continued overleaf ⟶

| PART 3 | **Medical Report**<br>**To be completed by your Doctor** |
|---|---|

To enable us, on behalf of your patient, to accurately assess his/her eligibility for a Companion Free Travel Pass please complete the medical report below. The medical information provided will be reviewed by one of the Department's Medical Assessors and will be treated in strictest confidence. Although treated as a confidential document this report will of necessity be dealt with by lay as well as medical persons.

1. Patient's Details

| Name | PPS Number | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Address | Occupation | | | | | | | | |
| | Age | | | | | | | | |

2. Your patient since: ☐☐ ☐☐ ☐☐☐☐

3. Diagnosis (use BLOCK letters) ☐

4. Date Commenced ☐

5. How long do you expect this condition to continue? _____Years _____Months

6. Please answer all questions below. If answer is 'Y' please give details in box provided.

* Relevant Investigations → Y/N ☐ ☐

* Hospital Admissions → Y/N ☐ ☐

* Attending a Specialist → Y/N ☐ ☐

* On Medication → Y/N ☐ ☐

* Other Treatment → Y/N ☐ ☐

7. If you have any additional information in this case, give details here: ☐

8. Does the Patient use a wheelchair for mobility, on a permanent basis? Yes ☐ No ☐

9. Is the applicant registered with the National Council for the Blind or National League of the Blind of Ireland Yes ☐ No ☐

| PART 3 Continued | Medical Report To be completed by your Doctor |
|---|---|

10. Indicate the degree to which the patient's condition has affected his/her ability in ALL of the following areas:

| | Normal | Mild | Moderate | Severe | Profound |
|---|---|---|---|---|---|
| Mental Health | ☐ | ☐ | ☐ | ☐ | ☐ |
| Learning | ☐ | ☐ | ☐ | ☐ | ☐ |
| Consciousness | ☐ | ☐ | ☐ | ☐ | ☐ |
| Balance | ☐ | ☐ | ☐ | ☐ | ☐ |
| Vision | ☐ | ☐ | ☐ | ☐ | ☐ |
| Hearing | ☐ | ☐ | ☐ | ☐ | ☐ |
| Speech | ☐ | ☐ | ☐ | ☐ | ☐ |
| Continence | ☐ | ☐ | ☐ | ☐ | ☐ |
| Reaching | ☐ | ☐ | ☐ | ☐ | ☐ |
| Lifting/Carrying | ☐ | ☐ | ☐ | ☐ | ☐ |
| Manual Dexterity | ☐ | ☐ | ☐ | ☐ | ☐ |
| Bending/Kneeling/Squatting | ☐ | ☐ | ☐ | ☐ | ☐ |
| Sitting | ☐ | ☐ | ☐ | ☐ | ☐ |
| Standing | ☐ | ☐ | ☐ | ☐ | ☐ |
| Climbing Stairs | ☐ | ☐ | ☐ | ☐ | ☐ |
| Walking | ☐ | ☐ | ☐ | ☐ | ☐ |

11. A Medical Examination by one of the Department's Medical Assessors may be required to determine eligibility.

Is the patient fit to attend for Medical Examination? YES ☐ NO ☐

If NO give details here:

| SIGNATURE: Dr. | Doctor's Official Stamp |
|---|---|
| DATE / **DSFA Panel No.** | |
| ADDRESS | |

| PART 4 | Declaration to be completed by YOU |
|---|---|

**I wish to apply for a Companion Free Travel Pass to replace my standard Free Travel Pass.**

**I declare that all the details I have given are true and complete to the best of my knowledge and belief and that I am permanently residing at the address given at PART 1 of this application form.**

**I will notify the Department of Social and Family Affairs if there is any change in the details given, or if I no longer satisfy ANY of the conditions of the Free Travel Scheme.**

| YOUR Signature<br>Or Mark | DATE |
|---|---|

**(NOT Block Letters)**

**If the applicant is not able to sign, his/her mark should be made and witnessed. The witness should sign below.**

| Signature<br>of Witness | DATE |
|---|---|

**(NOT Block Letters)**

| Address<br>of Witness |
|---|

**This completed application form should be sent to:**

Free Travel Section
Social Welfare Services
College Road
Sligo

LoCall: 1890 500 000 (from the Republic of Ireland only)

Note: The rates charged for using 1890 (LoCall) numbers may vary among different service providers.

## FOR OFFICE USE ONLY

This pass is issued if the claimant is considered to be medically unfit to travel unaccompanied. In this case the applicant is considered to be:

Suitable ☐ Not Suitable ☐ More Medical Evidence Required ☐

Signed: _____ Date: _____
DSCFA Medical Advisor

**DATA PROTECTION**

We, the Department of Social and Family Affairs, will treat all information and personal data you give as confidential. We will only disclose it to other people or bodies in accordance with law.

Explanations and terms used in this form are intended as a guide only and do not purport to be a legal interpretation.