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## DRIVER REHABILITATION REFERRAL FORM

### CLIENT / PATIENT INFORMATION

Clients First/Last Name: \_\_\_\_\_

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

Best Contact Name & Number: \_\_\_\_\_

Primary Diagnosis: \_\_\_\_\_

Reason for Referral: **Occupational Therapy (OT) Driving Evaluation + Treatment**

Are you aware of any other medical/visual concerns which may impact fitness to driving: YES or NO. If yes, please explain:

\_\_\_\_\_

Is the patient on medications which may impact fitness to drive? YES or NO.  
If yes, please explain:

### Referral Source Information

Physician Name (Please Print) : \_\_\_\_\_

License Number: \_\_\_\_\_ NPI: \_\_\_\_\_

Do you approve of this patient's participating in occupational therapy, driving evaluation and treatment? YES or NO

Physicians Signature : \_\_\_\_\_ Date: \_\_\_\_\_

**Please return referral to Adaptive Driving Idaho via fax or email**

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**ADAPTIVE DRIVING IDAHO, PLLC**  
*The key to driving independence*