Date & Phone:

Name:

Address:

Email:

|  |  |
| --- | --- |
| DOB: | Driver License #: |
| DL Expiration: | DL Restriction(s): |

Why are you being referred for our services?

Medical Diagnoses and pertinent history:

Do you use a wheelchair? Yes  No

Can you transfer by yourself? Yes  No

When did you last see an eye doctor?

Do you currently drive? Yes  No

How many years have you been driving?

If so, what model/year of vehicle?

If not, when, and why did you stop?

Have you had any accidents or tickets in the last 5 years? Yes  No

If yes, please explain:

What type of environment do you drive?

Residential (up to 25 mph)

Moderate traffic and speed (2-4 lanes up to 50 mph)

Heavy traffic (4-6 lanes 50-55 mph)

Interstate (>55 mph)

Rural roads (2 lanes up to 50 mph)

Night

What are your concerns with driving?

What are your goals for the driving program?

Have you had a seizure in the last 6 months? Yes  No

Please list your medications:

Physician Name:

Physician Phone:

Physician Fax:

Physician Address:

Do you consent to communication with your physician? Yes  No

Signature: