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: