OT Driving Order Request

DRIVING Evaluation Referral

1. **Please complete and return this order request for an Occupational Therapy Driving Evaluation & Treatment for this patient.**

First Name: _____ Last Name: _____ Date of Birth: _____ Home Phone: _____

Best Contact Name & Number (if not client) _____

Referring Physician _____ Contact _____

Reason for referral _____ Medical Diagnosis _____

Questions for Referring Physician

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

3. Are you aware of any other medical/visual conditions which may affect this person's fitness to drive? YES or NO
   If yes, please explain:

4. Do you approve this patient's participation in an occupational therapy, driving evaluation & treatment? YES or NO
   If yes, please explain:

5. Physician Signature: Date:

   Physician Name (please print): License Number:
   NPI:

Please fax the order to: Adaptable Therapy Services at (855) 395-0779

Adaptable Therapy Services, LLC

www.adaptabledriving.com

Phone (470) 549-1779