Abilities
OCCUPATIONAL THERAPY

phone:1-780-890-0393
fax: 1-780-669-5832
info@myabilities.ca
www.myabilities.ca

DRIVING EVALUATION REFERRAL FORM

REFERRAL DATE ______________

PATIENT INFORMATION

FULL NAME ______________

ADDRESS ______________

PHONE # ______________ CELL # ______________

DOB ______________ **PHN** ______________

EMAIL ______________

ALT. CONTACT NAME ______________

RELATION ______________

PH # (PRIMARY) ______________

PH # (OTHER) ______________

PLEASE CONTACT: ☐ Patient Directly ☐ Alt. Contact

PHYSICIAN INFORMATION

REFERRING PHYS. ______________

CLINIC ______________

PH # ______________ **FAX #** ______________

EMAIL ______________

FAMILY PHYS. ______________

CLINIC ______________

PH # ______________ FAX # ______________

EMAIL ______________

Please send correspondance to:

☐ Referring Physician **via:** ☐ Email ☐ Fax

☐ Family Physician **via:** ☐ Email ☐ Fax

REASON FOR REFERRAL

RELEVANT DIAGNOSIS: ______________

☐ Recent Surgery or Operation ☐ Recent Injury

Date of Operation/Injury (if applicable): ______________

REASON FOR REFERRAL (DETAILS):

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☐ Driver's Medical Completed

Driver's License Status *(as of Referral Date)*

☐ Valid ☐ Not Valid

REQUIRED EVALUATIONS:

DriveABLE Cognitive Results require a DriveABLE On-Road Evaluation to generate a Fitness to Drive report.

☐ Driving Evaluation On-Road Evaluation Only

☐ DriveABLE Cognitive & On-Road Evaluation

ADDITIONAL DETAILS (*CHECK ANY THAT APPLY):*

☐ Use of Mobility Aid ☐ Needs Vehicle Modifications

☐ Use of Hearing Aids ☐ Use of Corrective Lenses

☐ Upper Body, Hand, Finger Dexterity Issues

DRIVER'S LICENSE / MVID NUMBER

____

CLIENT ACKNOWLEDGMENT AND CONSENT

I acknowledge that my personal health information will be shared with Driver Fitness and Monitoring for the purpose of obtaining a temporary driver's license required for my driving evaluation. I understand that a tentative appointment will be scheduled, and payment is required in advance to confirm the appointment. Once the evaluation is complete, a copy of the report will be faxed to my physician(s), and I may collect a copy from them for my personal records. I understand that I may withdraw my consent at any time by contacting Abilities Occupational Therapy via the contact methods at the top of this form.

By signing below, I consent to the sharing of my personal health information as described above.

______________ ______________ ______________

Patient's Full Name (Printed) **Patient's Signature** **Date**

Please fill in this form and send it to Abilities Occupational Therapy via fax (1-780-669-5832) or email (info@myabilities.ca).
Thank you!