DriveAble Solutions
We teach people with disabilities to drive or drive again

Referral for Medical Driving Evaluation

Information of Patient Being Referred:

Patient Name: _____ DOB: _____

Contact Name: _____ Phone #: _____

Reason for Referral/Diagnosis: _____

_____

**Check All That Apply:*

☐ New Driver

☐ Cognitive Concerns

☐ Visual Concerns

☐ Needs Adaptive Equipment (Hand Controls, Modified Vehicle, etc.)

☐ Recent Accident/Tickets/Driving Concerns

Physician Information:

Physician Name: _____

Physician Signature: _____

Office Phone #: _____ Office Fax #: _____

*If there are any concerns (cognitive, physical, visual, etc.), it is helpful if you are able to send any relevant doctor's records, therapy notes, neuropsychological testing, etc. that expand on these areas of concern.

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