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Prescription for Occupational Therapy Driving Evaluation, on road assessment and training
as indicated

Patient's Name: _____ DOB: _____

Address: _____

Primary Medical Diagnosis (and ICD-10):

Co-Morbidities: _____

Precautions: _____

Contact person's name and phone number:

Purpose of driving evaluation:

- ☐ Concern over continuation of driving skills due to chronic medical conditions
- ☐ Return to driving after medical change
- ☐ Readiness to drive evaluation for a new driver

Anything further for the clinician to know: _____

Physician Name: _____

Physician Signature: _____

Date: _____