



driveonrocks.org

PHONE 585.271.1894 TOLL-FREE 1.877.823.7483 FAX 585.442.6883

REFERRAL FORM

NAME: _____ DOB: _____ SEX: M ___ F ___

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (____) _____ Cell (____) _____ Work: (____) _____

E-MAIL: _____

Check Desired Location for Service: <input type="checkbox"/> Rochester <input type="checkbox"/> Syracuse <input type="checkbox"/> Utica <input type="checkbox"/> N. Tonawanda (Buffalo)	
Referral for: <input type="checkbox"/> Driver Evaluation <i>Physician approval required</i>	<input type="checkbox"/> Driver Training – Beginner
<input type="checkbox"/> Equipment Evaluation for Driver <i>already experienced with Driving Aids</i>	<input type="checkbox"/> Driver Training – Experience
	<input type="checkbox"/> Equipment Evaluation for Passenger

LIST DISABLING CONDITION (reason for this referral): _____

<p>MEDICAL SUMMARIES REQUIRED FOR ALL DRIVER EVALUATION REFERRALS <i>Please include admission and discharge summaries if hospitalized in the past year.</i></p> <p>Brain Injury Diagnosis or Loss of Consciousness – <i>Include neuropsychological evaluation and medical discharge reports.</i></p>
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Which document do you have? License Permit ID Card
 What state is your document? New York Other (specify): _____
 Is your license or permit currently suspended or revoked? YES NO
 When did you last operate a motor vehicle? _____
 How did you learn about the DriveOn program? _____

Is the individual a Medicaid Recipient? <input type="checkbox"/> YES <input type="checkbox"/> NO. Does the individual have Health Insurance? <input type="checkbox"/> YES <input type="checkbox"/> NO
INSURANCE COMPANY _____ PRIOR APPROVAL NEEDED? <input type="checkbox"/> YES <input type="checkbox"/> NO
SUBSCRIBER # _____ AUTHORIZATION # _____

COMMENTS: _____

Return completed referral to: **Rochester Rehabilitation- Physical Rehabilitation Services**
 1000 Elmwood Avenue, Suite 600, Rochester, New York 14620
 PHONE: 585.271.1894 / TOLL FREE: 1.877.823.7483 / FAX: 585.442.6883

Referred by (please print name): _____ Date: _____

Referring Physician Specialty: GP ortho neuro gerontology psych internal med cardio Other: _____

Agency/Program: _____ Address: _____

City: _____ State: _____ Zip: _____ PHONE: (____) _____

A PHYSICIAN'S ORDER FOR AN OCCUPATIONAL THERAPY EVALUATION OF FUNCTIONAL ABILITY TO DRIVE IS REQUIRED. THIS FORM MAY SERVE AS ORDER IF PHYSICIAN'S SIGNATURE APPEARS BELOW. (IF PREFERRED, ATTACH PRESCRIPTION.)
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Physician's Signature _____	Date _____	REGISTRATION # _____	NPI # _____
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F:/gruber/Eval-Train/Masters: 1Referral DRIVE ON 4-23-09, 5-11-09, 2-18-10, 3-24-10, rev 4-23-10, 9-3-10