

**ROCHESTER REHABILITATION CENTER**

University Hospital/Syracuse • KALEIDA DeGraff Hospital/N. Tonawanda • Faxton-St. Luke's Healthcare/Utica

**DRIVEON REFERRAL**

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ SEX: M \_\_ F \_\_ Soc.Sec # \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE (please include area code): (\_\_\_\_) \_\_\_\_\_ Other \_\_ Cell \_\_ Work: (\_\_\_\_) \_\_\_\_\_

Would you like to receive correspondence & reports by EMAIL? \_\_ YES \_\_ NO (PLEASE PRINT CLEARLY BELOW)

E-MAIL: \_\_\_\_\_

<b>Check Desired Location for Service: __ Rochester __ Syracuse __ Utica __ N. Tonawanda (Buffalo)</b>	
<b>Referral for:</b>	<b>__ Driver Training- Beginner</b>
<b>__ Driver Evaluation</b> <i>Physician approval required</i>	<b>__ Driver Training – Experience</b>
<b>__ Driver Evaluation Senior Program</b> <i>(One appt - 2 1/2 hours) Physician approval not required.</i>	<b>__ Equipment Evaluation for Passenger</b>
<b>__ Equipment Evaluation for Driver</b> <i>already experienced with Driving Aids</i>	

How did you learn about the Driver Rehab program? \_\_\_\_\_

Did individual drive prior to disability? \_\_ YES \_\_ NO. If yes, how long? \_\_\_\_\_

Does individual have valid New York State Driver's License or Learner's Permit? \_\_ YES \_\_ NO

Does the individual's license currently have a medical or other suspension in effect? \_\_ YES \_\_ NO

<b>MEDICAL SUMMARIES REQUIRED FOR ALL DRIVER EVALUATION REFERRALS -</b> <i>Please include admission and discharge summaries if hospitalized in the past year.</i>
<b>Brain Injury Diagnosis</b> – <i>Include a neuropsychological evaluation and medical discharge reports.</i>
<b>Loss of Consciousness</b> – <i>Include a neuropsychological evaluation if any incident has occurred within past 12 months.</i>
<b>LIST DISABLING CONDITIONS</b> (See above for details of medical reports that should accompany referral): _____

Is the individual a Medicaid Recipient? \_\_ YES \_\_ NO. Does the individual have Health Insurance? \_\_ YES \_\_ NO

INSURANCE COMPANY _____	PRIOR APPROVAL NEEDED? YES NO
SUBSCRIBER # _____	AUTHORIZATION # _____

Has individual participated at Driver Evaluation/Training before? \_\_ YES \_\_ NO

COMMENTS: \_\_\_\_\_

Return completed referral to:  
**Rochester Rehabilitation Center – Physical Rehab 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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