DriveOn
A division of Rochester Rehabilitation Center
an Ability Partners agency
www.rochesterrehab.org/driveon

REFERRAL FORM

NAME:_____ **DOB:**_____ **SEX: M** ☐ **F** ☐

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

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

E-MAIL:_____

Referral for:

Beginner Driver
- ☐ Permit Preparation
- ☐ Driver Evaluation
- ☐ Driver Training
- ☐ **Equipment Evaluation for Passenger**

Experienced Driver
- ☐ Driver Evaluation-no equipment
- ☐ Driver Evaluation-with equipment
- ☐ Driver Training

REFERRAL SOURCE:_____

Which document do you have? ☐ License ☐ Permit ☐ ID Card Exp Date:_____ Lic/Permit # _____

What state is your document? ☐ New York ☐ Other (specify): _____

Is your license amended for adaptive equipment? ☐ Yes ☐ No

Is your license or permit currently suspended or revoked? ☐ Yes ☐ No

When did you last operate a motor vehicle? _____

Diagnosis:_____ **Onset Date**:_____

Current Medications that may affect safe driving:_____

Payment will be provided by:

☐ Client or family member

☐ Self Direction Program: _____

Contact Name: _____ Email _____

PHYSICIAN APPROVAL AND MEDICAL SUMMARIES REQUIRED FOR ALL DRIVER EVALUATION REFERRALS

Please include admission and discharge summaries if hospitalized in the past year.

Brain Injury Diagnosis **or** Loss of Consciousness **– *Include neuropsychological evaluation and medical discharge reports.***

Physician (**please print name**):_____

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

Agency/Program:_____ Address:_____

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

_____ _____ _____

Physician's Signature Date REGISTRATION # NPI #

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