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**	**Experienced Driver**
	☐ Permit Preparation	☐ Driver Evaluation-no equipment
	☐ Driver Evaluation	☐ Driver Evaluation-with equipment
	☐ Driver Training	☐ Driver Training
	☐ **Equipment Evaluation for Passenger**	

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**:_____

Seizure within the last year? No ☐ Yes ☐ 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