PASSENGER EQUIPMENT EVALUATION REFERRAL

NAME:_____DOB:_____SEX: M__ F__

PARENT'S NAME: _____

ADDRESS:_____CITY:_____STATE:_____ZIP:_____

HOME PHONE (*please include area code*): (____)_____Other __Cell __Work: (____)_____

Medical Diagnosis:	
Wheelchair Make and Model:	
Type of Vehicle for Transportation:	**Year_____ Make_____ Model_____ Mileage_____** **__Please check if vehicle consultation is required**

Return completed referral to:

Rochester Rehabilitation Center – DriveOn

1000 Elmwood Avenue, Suite 600, Rochester, New York 14620

PHONE: **585-271-1894 ext. 1301 /** FAX: **585-442-6883**

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

Agency/Program:_____Address:_____

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

Email_____

Would you like to receive correspondence & reports by EMAIL? ___YES ___NO (PLEASE PRINT CLEARLY BELOW)

EModProviderAgency/Proj Manager :_____ Address:_____

City_____State_____ Zip_____ Phone: (____)_____

Name or Provider Agency/Project Manager Contact : _____ _____

E-Mail:_____

Payor_____Address:_____

City_____State_____Zip_____Phone: (_____)_____

Payor Contact:_____E-mail_____

Client Please note: You are welcome to look at vans prior to your appointment with DriveOn, however it is highly recommended that you do not purchase a van until after your visit. This will ensure that you have a vehicle that meets your needs and you will not accrue additional expenses that are not covered by your sponsoring agency.