REFERRAL FORM

NAME:____DOB:________________SEX: M___ F___

ADDRESS:______________________________________ CITY:________________________STATE:______ZIP:____________

HOME PHONE: (_____)_____________________ CELL (_____)___________________ WORK: (_____)__________________

E-MAIL :____

Check Desired Location for Service: __Rochester __Syracuse __Utica __ N. Tonawanda (Buffalo)

Referral for:	**Beginner Driver**	**Experienced Driver**
	___Permit Preparation	___Driver Evaluation – no equipment
	___Driver Evaluation	___Driver Evaluation – with equipment
	___**Equipment Evaluation for Passenger**	*Driver Training may be provided if indicated by Evaluation*

REFERRAL SOURCE:____

Which document do you have? ___License ___Permit ___ID Card Expiration Date:___________
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? ____

CURRENT DIAGNOSIS (please list) Onset Date:_________________

o Aging
o Dementia/Cognitive Disorder :____
o Congenital Disability: ____
o Developmental Disability:____
o Learning Disability:____
o Mental Health Condition: ____
o Medical Condition: ____
o Physical Impairment: ____
o Visual Impairment: ____
o Seizure within the last year? ___Yes ___No Date:____________________

Current medications that may affect safe driving: ____

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 – DriveOn**
1000 Elmwood Avenue, Suite 600, Rochester, New York 14620

PHONE: 585.271.1894 | TOLL FREE: 1.877.823.7483 | FAX: 585.442.6883