



REFERRAL FOR DRIVING ASSESSMENT

Client's Name: _____

Address: _____

Date of Birth: _____ Tel. No.: _____

Contact person with whom to arrange app't.: _____ Tel. No: _____

Referring Physician: _____ Tel. No.: _____

Date of Referral: _____

Family Physician: _____ Tel. No.: _____

Has client agreed to evaluation? yes no

Note: The minimum fee for the driving assessment in Occupational Therapy is \$500.00.
Please ensure that the client is aware that there is a fee.

BRIEF HISTORY (including primary and secondary diagnosis): _____

History of Seizures: yes no Date of last seizure: _____

SUMMARY OF PHYSICAL and/or COGNITIVE DEFICITS: _____

REASON FOR REFERRAL FOR DRIVING ASSESSMENT: _____

ADDITIONAL INFORMATION RELEVANT TO DRIVING: _____

MEDICATIONS: _____

Please send any relevant information, including diagnostic reports, discharge summaries, and neuropsychological reports.

Please fax completed form to our Admitting Department: (613) 733-8336

Ref::msword/driving/referral.frm