

OCCUPATIONAL THERAPY DRIVER REHABILITATION PROGRAM

COMMUNITY REFERRAL

MEDICAL PROVIDER TO COMPLETE (DEBE LLENARLO EL PROVEEDOR DE SALUD)

Date Referred:	Date Received:
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Client Name:	Cell Phone: ()	Home Phone: ()
Emergency Contact:	Relationship:	Phone: ()

Order item: <input type="checkbox"/> OT Driving Evaluation and Training	
DIAGNOSIS (Required):	Onset Date:
RELEVANT MEDICAL HISTORY/MEDICATIONS:	
PRECAUTIONS:	
REASON FOR REFERRAL :	
TO ADDRESS PROBLEMS RELATED TO:	
<input type="checkbox"/> Ability to return to driving <input type="checkbox"/> Driver license determination / DMV Procedures	<input type="checkbox"/> Information for adaptive driving equipment <input type="checkbox"/> Information for modified vehicles
COMMENTS:	

Prescribing Practitioner Information:

REFERRING PHYSICIAN'S PRINTED NAME:		DATE:
First Name:	Last Name:	
REFERRING PHYSICIAN SIGNATURE		MEDICAL LICENSE#:
PHONE#:	FAX#:	

RRI#:	RLA#:
NAME:	
DOB:	