DRIVEWELL REHAB, LLC
EVALUATION AND TRAINING SERVICES

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Physician Referral Form

Please complete the following referral form if you would like your patient's driving ability assessed by DriveWell Rehab, LLC. * Please also provide the most recent office visit notes. Upon completion of the evaluation, DriveWell Rehab, LLC will send you a report with the results and recommendations. If you have any questions, please feel free to contact us. Thank you.

Patient Information

Name _____ Date of Birth _____ Date _____

Street Address _____ Apt./Unit # _____ City _____ State _____ Zip Code _____

Mobile Phone _____ Home Phone _____

Diagnosis

Diagnosis _____ Date _____ Seizure ☐ Yes ☐ No Date _____

License/Driving Status

License # _____ Comments _____

License valid, expired, pending medical or suspended.
☐ Valid ☐ Expired ☐ Pending Medical ☐ Medically Recalled

List current medications that may influence driving performance:

_____

Are you aware of any other medical or visual conditions that may affect this individuals ability to drive safely?

☐ Yes
☐ No
If yes, please explain. _____

Is there any mobility issues that would impact their ability with entering a vehicle?

☐ Yes
☐ No
If yes, please explain. _____

Is the individual medically stable to participate in a driver's evaluation and training if recommended?

☐ Yes
☐ No
If no, please explain. _____

Healthcare Provider's Information

Physician's Name _____ NPI# _____

Contact # _____ Fax# _____

Address/State/Zipcode _____

Physician Signature

_____ Signature _____ Date