Occupational Therapy Services, Inc.

DRIVING SOLUTIONS

Driver Evaluations, Training, and Rehabilitation
for the older driver and person with a disability

DRIVING ASSESSMENT REFERRAL FORM

Name: _____ **D.O.B.:** _____

Phone: _____

Diagnosis/onset: _____ **ICD9 CODE:** _____

I am concerned about his/her driving safety because of:

__ **Impaired cognition**
__ **Memory loss**
__ **Visual deficit**
__ **New diagnosis affecting driving**
__ **Compromised physical status**
__ **Coordination problems**
__ **Patient's concern**
__ **Family member concern**
__ **Other:** _____

PLEASE SCHEDULE

❑ **Evaluation and treatment**

__ Pre-road Clinical Assessment
__ Behind-the Wheel Driving Assessment
__ Equipment and Vehicle Modification Assessment and Training
__ I-ADL training: Community Mobility

_____ _____
MD signature Date

Office phone number:

Phone: 541/686-3524 FAX: 541/686-2683 www.DrivingSolutionsOregon.com
492 E 13th Avenue Suite 101 Eugene Oregon 97401