FACT
SERVICES LTD.

Functional
Assessments
Consultation
and Therapy

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admin@otfacts.ca

Driver Evaluation Referral

Client Name: _____

Address: _____

_____

Phone Number: _____

Alternate: _____

Date of Birth: _____

P.H.N. _____

Diagnosis and Date of Onset: _____

_____

Potential problems as they relate to driving:

☐ Age related changes ☐ Physical functioning
☐ Visual skills ☐ Perceptual abilities
☐ Mental processing ☐ Other (please explain)

_____

Medications: _____

Physican Name: _____

Phone: _____

Address: _____

_____

Referred by:

☐ Physician ☐ Self-referral ☐ Family ☐ Physician

Signature: _____

Date: _____

Referral received: _____

Clinic date booked: _____

Road-test booked: _____