ADAPTIVE INDEPENDENCE Missoula

Comprehensive Driving Evaluation Referral Form

Please attach a copy of the patient's most recent visit notes and an updated medication list.

Patient Name: _____ DOB: _____ Gender: _____

Address: _____ Phone: _____

Primary Diagnosis: _____

Medical Precautions(ie. Cardiac, Seizure, etc.): _____

Referral for (check boxes that apply):

- ☐ Safe Driving Evaluation & Training
- ☐ Adaptive Equipment Assessment and Order - As Needed
- ☐ Other: _____

History of Seizures: ☐ **Yes** ☐ **No** Onset: _____ Date of Last Seizure: _____

Recent coma and/or LOC: ☐ **Yes** ☐ **No** Onset: _____ Length of Coma: _____

Additional pertinent details about patient's mobility, vision, perception, cognition, or behavioral status: _____

_____

Physician Name: _____ Phone: _____

Address: _____ Fax: _____

In your professional opinion, does this patient have the physical and cognitive skills to safely participate in a comprehensive driving/behind-the-wheel evaluation?

☐ **Yes** ☐ **No** Details: _____

Physician Signature: _____ Date: _____