easterseals Rehabilitation Center
ATS • Assistive Technology Solutions
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Driver's Rehabilitation Physician Referral Form

Patient's Name:_____

Patient's DOB:_____**Patient's Phone**:_____

☑ **I would like this patient to receive an Occupational Therapy evaluation and treatment of driving related deficits.**

Diagnosis(es)_____

_____

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Please check one of the following:

☐ I release this patient to drive upon successful evaluation and/or training.

☐ I would like to council this patient upon successful evaluation and/or training before they return to driving.

Physician Name:_____ **Physician Phone:**_____

Physician Signature:_____**Date**:_____

Notes or additional comments:_____

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