

KALEIDA HEALTH/DEGRAFF HOSPITAL/ROCHESTER REHABILITATION CENTER
DRIVER EVALUATION/TRAINING REFERRAL

NAME: _____ DOB: _____ SEX: M ___ F ___ PHONE: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

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|----------------------|--|--|
| Referral for: | Driver Evaluation Equipment Eval. For Driving Vehicle Consult | Driver Training if indicated Equipment Eval. for Passenger Equipment Inspection |
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Did individual drive prior to disability? YES NO. If yes, how long? _____

Does individual have valid New York State Driver's License? YES NO

Does individual have valid New York State Learner's Permit? YES NO

Medical Summaries required for all driver evaluation referrals - Please include admission and discharge summaries if hospitalized in the past year.

Mental Retardation or Learning Difficulties Diagnosis - Include most recent psychological testing.

Brain Injury Diagnosis - Include a neuropsychological evaluation and medical discharge reports.

Loss of Consciousness - Include a neuropsychological evaluation if any incident has occurred within past 12 months.

LIST DISABLING CONDITIONS (See above for details of medical reports that should accompany referral):

Does the individual have Health Insurance? YES NO

| | |
|-------------------------|-------------------------------|
| INSURANCE COMPANY _____ | PRIOR APPROVAL NEEDED? YES NO |
| SUBSCRIBER # _____ | AUTHORIZATION # _____ |

Is the individual a Medicaid Recipient? YES NO

Has individual participated at Driver Evaluation/Training before? YES NO

COMMENTS: _____

Return completed referral to: DRIVER EVALUATION/TRAINING SERVICES

**Rochester Rehabilitation Center
1000 Elmwood Avenue, Suite 600
Rochester, NY 14620-3097**

TOLL FREE PHONE: 1-877-823-7483 FAX # (585) 295-8029

Referred by (please print name): _____ Date: _____

Agency/Program: _____ Address: _____

City: _____ State _____ Zip: _____ Phone: _____

A PHYSICIAN'S ORDER FOR AN OCCUPATIONAL THERAPY EVALUATION OF FUNCTIONAL ABILITY TO DRIVE IS REQUIRED. THIS FORM MAY SERVE AS ORDER IF PHYSICIAN'S SIGNATURE APPEARS BELOW. (IF PREFERRED, ATTACH PRESCRIPTION.)

Physician's Signature Date REGISTRATION #