



SERVICES LTD.

Functional  
Assessments  
Consultation  
and Therapy

**Address**

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Prairie No.1,  
Alberta T8W 0H2

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# 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: \_\_\_\_\_