

Parkwood Institute
Driver Assessment and Rehabilitation Centre
Driver Assessment and Rehabilitation Program/DriveABLE



Mailing address **Location**
PO BOX 5777, STN B 550 Wellington Road
London, ON N6A 4V2 London ON N6C 0A7

Tel: (519) 685-4070 Fax: (519) 685-4066

Referral (Please forward any relevant medical consultation notes or reports)

Name: _____

Address: _____

Phone: _____ Date of Birth: _____ Date of Referral: _____

1. Diagnosis (date of onset and details): _____

2. Has your patient been informed of his/her diagnosis? Yes No

3. This client's condition is likely to: Improve Remain Stable Deteriorate

4. Has a change in medical condition been reported to the Ministry of Transportation indicating that this client may be unsafe to drive? Yes No Uncertain

5. Has Physician asked patient not to drive? Yes No

6. Does this client use any of the following mobility devices?
 Crutches/cane/walker Manual wheelchair Power wheelchair/Scooter

7. Does this client require assessment of vehicle modifications or adaptive driving equipment?
 Yes No Uncertain

8. Does this client exhibit any visual deficits? Yes No

9. Please describe any cognitive behavioral issues? _____

10. Has this client had a seizure in the last year? Yes No

11. Please list medications: _____

Physician's Name: _____

Address: _____ Postal Code: _____

Physician's Signature: _____ Date: _____

For Office Use Only:

Vision: Yes _____ No _____ Car _____ Minivan _____

OT Initial: _____

DARP

DriveABLE