DRIVER REHABILITATION SERVICES INC.
1377 Cormorant Road, Ste. 204 – Ancaster, ON. L9G 4V5
PHONE: (905) 296.3569 FAX: 1 (866) 797-8915
www.driver-rehab.com

REFERRAL FORM

To the Referring Agent: Answering the following questions will allow us to provide a more complete evaluation of the client's needs as driver and/or passenger.
Your signature at on Pg. 2 will be considered a written prescription for a driving evaluation, and treatment/remediation, if indicated.
We will send you copies of the Assessment and subsequent Reports. Contact us at 905-296-3569 if you have any questions concerning the assessment and/or treatment/remediation.
Thank you.

CLIENT INFORMATION

Client's Name: ____

Address: ____
____

Phone: (home) ____________________ (work/cell) ____________________

Date of Birth: ____________________

Drivers Licence: ____________________

Diagnosis/Disability ____________________ Onset / M.V.C. Date. ____________________

Past Medical History (relative to the task of operating a motor vehicle)
____ *(Please attach history if available)*

PLEASE CIRCLE APPROPRIATE ANSWER & ADD COMMENTS AS NECESSARY:

1. Visual limitations? (acuity, double vision, night myopia etc.) YES ____________ NO ____________
2. Visual field cut? YES ____________ NO ____________
3. Seizure Disorder? YES ____________ NO ____________
   Date of last seizure ____________
4. Dizziness or syncope? YES ____________ NO ____________
5. Cardiac precautions? YES ____________ NO ____________
6. Orthopedic concerns that may impact on driving? YES ____________ NO ____________
7. Could present medications influence driving? YES ____________ NO ____________
   Please provide list : ____________ ____________ ____________
   ____________ ____________ ____________
8. Have you reported this client to the Ministry of Transportation? YES ____________ NO ____________

9. What are your concerns regarding this patient returning to driving or continuing to drive? Include any external stressors that you may feel are applicable:
____
____
____

10. Is this a recurring or ongoing medical condition or problem? ____________________

11. Is this the first time a driver evaluation has been attempted? Explain: ____________________
____

12. Has this person suffered any lapses of memory or become forgetful recently? Explain: ____________________
____

REFERRAL FORM
Client's Name: ______________________________

Driver Competency Assessment ©

This report and analysis will provide the client with an objective evaluation of their risk management skills. The score for an average driver is 5.0. We would expect our client to achieve or exceed this score. Documentation will be provided upon request with details of this protocol and analysis. This specialized evaluation holds two benefits in completing a client's program. It provides the client with a physical, visual readout of their strengths and weaknesses in varying stressful and demanding situations along a controlled route. It is a one hour standardized assessment that produces an accurate measure of a driver's risk management skills, a significantly different focus from a regular MTO driving test. I am enclosing sample results of this protocol so that you can better understand the benefit of **including this assessment in the client's program.**

DCA 1 - To assist new-to-the-road drivers who have never driven. To assess seniors facing a change in their vehicle use. To assess licensed drivers returning to driving following some form of trauma or long illness.This test is administered in a relatively familiar environment, particularly when the older driver is involved. No distracter conditions are undertaken in this evaluation.

DCA 2 – To assess drivers who are experienced at driving on their own. This assessment is more complex than the level 1 assessment, and therefore reflects the driver's abilities in a more difficult environment and under specific distracter conditions. This assessment can be used for all license classificants including commercial drivers. Should an individual experience difficulties with this level of assessment, it is suggested to either initiate some remedial training program, or to re-assess the client using **DCA 1** and recommend a degree of self-restricting with regard to vehicle use.

Please indicate (x) which assessment, test, or procedure is required:

	1. Driver/Passenger Assessment Recommendations & Report (related on-road trauma)		4. Driver Competency Assessment 1 (DCA protocol) New Driver/Senior Driver (as above)
	2. Functional Assessment, Visual Assessment Recommendations & Report (related to specific driving issues)		5. Driver Competency Assessment 2 (DCA protocol) – in conjunction with # 1
	3. In-vehicle Rehabilitation/Remediation (preapproved Treatment Plan)		6. Driver Competency Assessment 2 (DCA protocol) – standalone assessment

INSURANCE INFORMATION: (Please Print Clearly)

Insurance Company: ______________________________
Street Address: ______________________________
City: ______________________ **Prov.:** _____ **Postal Code:** ______________

Adjuster's Name: ______________________________

Claim #: ______________________ **Policy #:** ______________________

MEDICAL PROFESSIONAL INFORMATION: (Please Print Clearly)

Name of Medical Professional: ______________________________
Street Address: ______________________________
City: ______________________ **Prov.:** _____ **Postal Code:** ______________

Thank you for your referral.

Mary K. Skirrow

Driving Therapist, Driver Competency Assessment Evaluator,
Owner/Director

Please Mail to: Driver Rehabilitation Services Inc.
1377 Cormorant Road, Suite 204
Ancaster, ON. L9G 4V5
Or Fax to: 1-866-797-8915

For office use only:

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