Skill Builders
DRIVER REHABILITATION

SERVING ALL OF ONTARIO

MEDICAL INFORMATION / DRIVING REFERRAL FORM
DRIVER EVALUATION & TRAINING PROGRAM

Client Information

Client Name: _____ Age: _____ Date of Birth: _____
Address: _____
Contact No. ☎: _____

Primary Diagnosis: _____
Any history of seizures? ☐ Yes ☐ No If yes, please explain _____
_____
Will this patient's medications affect their ability to operate a motor vehicle? ☐ Yes ☐ No
To your knowledge, has this patient's driver's license been medically suspended? ☐ Yes ☐ No
It is **my opinion** that this patient is **medically stable to participate** in a Driver Evaluation:
☐ Yes ☐ No
Diagnosis/Comments/Precautions: _____
_____
_____
_____
_____

Location Requested

☐ Barrie ☐ Collingwood ☐ Kitchener ☐ Oakville
☐ Sault Ste Marie

Referrer Information

Physician/NP Name: _____ Signature: _____
Address: _____
Contact No. ☎: _____ Fax: _____
Date of Referral: _____