# REQUEST FOR SERVICE
## Driver Rehabilitation

**Date**

**REFERRED BY** Name/Organization

Phone Fax

3rd Party Insurance File/Claim#

Contact Phone Fax

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**CLIENT NAME** Phone

Valid driver's licence Yes No City

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**SERVICE REQUESTED** Rehabilitation (driving) needs evaluation

Rehabilitation sessions 5 sessions 8 sessions Other ____

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**REASON FOR REFERRAL:**

**Injury** Date of injury: Client fully recovered Yes No

Did injuries result from a motor vehicle incident? Yes No

**Medical Event/condition**: Date of event: Client fully recovered Yes No

CVA Parkinson's Dementia MS Other:

**Symptoms:** (indicate all that apply)

Right-sided weakness Cognitive impairment Anxiety/stress (driving related)

Left-sided weakness Motor impairment (explain)

Generalized weakness Sensory impairment (explain)

Amputation Lt leg Rt leg Lt arm Rt arm Prosthesis If yes, How long?

Paralysis Lt leg Rt leg Lt arm Rt arm

Other (Explain):

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**VEHICLE NEEDS**

No modifications needed Currently uses modified vehicle (explain):

Anticipate modified vehicle will be needed (explain):

Comments

Fax to 1-877-807-4669