Client Referral Form

Driver Re-hab. Team
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Client Information

Client to be Referred	**Referring Party**
Name: Address: City: Province: Postal Code:	Name: Title: Company: Address: City: Province: Postal Code:
Phone: ( ) Fax: ( )	Phone: ( ) Ext. Fax:
D.O.B. / / (yy/mm/dd)	Date of Referral: / / (yy/mm/dd)

To be eligible for the driver's program you must have:	
1. Valid Driver's License (TDL)	License # ____________________________ Expiry Date: _________________ License Class: _________________
2. Release from your doctor	Submitted with Referral ____________ Release note to follow ____________

Reasons for Referral:

Relevant Medical Information:

Relevant Social Factors	
Language (other than English) _______________ Language translation required _______________	Other Social Concerns

Please Indicate Services Requested for Client	
□ Assessment of Driving Anxiety Concern □ Basic Road Test Preparation Training	□ Driver Re-training □ Driver Vehicle Modification Training

Adaptive Driving Equipment (if applicable)	
Currently Set up? Yes _________ No _________	If no, previous experience

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Insurance Information (if applicable)		
Company Name:	Contact Person:	Title:
Address:	Phone:	Fax:
City:	Province:	Postal Code:
Claim #	Date of Loss: / /	(yy/mm/dd)

Assessment and Treatment Services *(for office use only)*	
□ Accupuncture □ Hypnotherapy □ Massage □ Physiotherapy	□ Occupational Therapy □ Psychotherapy □ Therapeutic Relaxation Techniques

Additional Pages Included # ____________ Billing To: ____Client ____Insurance ____Other

Referer's Signature: ____ Date: _____________________

(for consideration for privacy of personal information, please do not send this form by email)

Please forward by fax or mail.

Thank you for your referral!