

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
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Please Indicate Services Requested for Client

<input type="checkbox"/> Assessment of Driving Anxiety Concern <input type="checkbox"/> Basic Road Test Preparation Training	<input type="checkbox"/> Driver Re-training <input type="checkbox"/> Driver Vehicle Modification Training
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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 <i>(for office use only)</i>	
<input type="checkbox"/> Acupuncture <input type="checkbox"/> Hypnotherapy <input type="checkbox"/> Massage <input type="checkbox"/> Physiotherapy	<input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Psychotherapy <input type="checkbox"/> Therapeutic Relaxation Techniques

Additional Pages Included # _____

Billing To: ___Client ___Insurance ___Other

Referrer'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!