St. Joseph's
HEALTH CENTRE GUELPH
Unstoppable Compassion

# Referral: Driving Rehabilitation Program

**REHABILITATION SERVICES**
100 Westmount Road
Guelph, Ontario, N1H5 H8

Email: driving@sjhcg.ca
Tel. #: 519-767-3433
Fax #: 519-767-4160

**Client Information**

Name: _____

Date of Birth: _____
yyyy/mm/dd

Address: _____

_____

_____

Drivers License #:_____

Expiry Date: _____
yyyy/mm/dd

License Status: ☐ Valid ☐ Suspended

Is client currently driving? ☐ Yes ☐ No

Has the MTO been notified? ☐ Yes ☐ No

Preferred Phone Number: _____

Health Card Number: _____VC: _____

Contact person: _____

Primary Diagnosis: _____

Other Medical History related to driving: _____

_____

Comments or special considerations: _____

_____

*****Please attach any relevant consultation notes and cognitive assessments*****

**Referring Physician or Nurse Practitioner:** _____

**Address:** _____

**Phone:** _____ **Fax:** _____

**Signature:** _____**Date:** _____

**Primary Physician or NP:**_____**Fax:** _____

**Please fax completed referral to 519-767-4160**