ST. JOSEPH'S
HEALTH CENTRE GUELPH

REHABILITATION SERVICES
100 Westmount Road
Guelph ON N1H 5H8

Tel: 519.824.6000 X.3414
Fax: 519.767.4160

REFERRAL
DRIVING ASSESSMENT PROGRAM

Name of Client: _____	Drivers License #: _____
Date of Birth: _____ (d) (m) (y)	Expiry Date: _____
Address: _____ _____	License Status: Valid ☐ Suspended ☐
Phone No: _____	Is Client currently driving? ☐ Yes ☐ No
	Health Card No: _____

Principal Diagnosis: (if Traumatic Brain Injury please attach neuropsychology report).

_____

Associated Conditions related to driving: _____

On Medication(s) that affect driving: ☐ Yes ☐ No

Other medical contraindication to driving: (i.e. seizures within the past year, etc.)

_____

Recent visual examination (within the past year) ☐ Yes ☐ No

Name of Client's Physician: _____

Physician's Mailing Address: _____

_____

Phone No: _____ Fax No: _____

Physician's Signature: _____ Date: _____

Send by fax or mail