# Driving Order - Adaptable Therapy Services

## DRIVING Evaluation Referral

1. **Please complete and return this order request for an Occupational Therapy/Physical Therapy Driving Evaluation & Treatment for this patient.**

First Name: _____ Last Name: _____ Date of Birth: _____ Home Phone: _____

Best Contact Name & Number (if not client) _____

Referring Physician _____ Contact _____

Reason for referral _____ Medical Diagnosis _____

## Questions for Referring Physician

2. Is the patient on medications which may interfere with fitness to drive? YES or NO
   If yes, please explain:

3. Are you aware of any other medical/visual conditions which may affect this person's fitness to drive? YES or NO
   If yes, please explain:

4. Do you approve this patient's participation in an occupational therapy/physical therapy, driving evaluation & treatment? YES or NO
   If yes, please explain:

5. Physician Signature: Date:

   Physician Name (please print): License Number:
   NPI:

## Please return the order to Adaptable Therapy at 1-855-395-0779