



Physician Prescription for OT Driver Evaluation

Client Name: _____

Address: _____

Telephone Number: _____

Diagnosis/Reason for evaluation _____

Current Medications: _____

Please check all that apply:

- _____ Seizure/loss of consciousness
- _____ Implanted cardiac defibrillator
- _____ Syncope
- _____ O2 sat level 88% or less at rest or with minimal exertion
- _____ FEV-1 level of 1-2 liters or less
- _____ Arthritis condition which renders the individual unable to perform self care
- _____ Alcohol/substance abuse
- _____ Behavioral issue/learning issue
- _____ Visual issues
- _____ Motor vehicle accident
- _____ License suspension/revocation
- _____ Cognitive issue
- _____ Medical clearance following change in health status

Referring Physician: _____

Physician Address: _____

Telephone Number: _____

Physician Signature

***In Massachusetts, an MD order is required for all Occupational Therapy referrals .*

*** See www.drivingsolutionsforyou.com for more information.*