DRIVING SOLUTIONS

Helping you make the right decision

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: _____

JUDY ROMANO | 508-878-9583
DRIVINGSOLUTIONSJUDY@GMAIL.COM