*Occupational Therapists and Certified Driving Rehabilitation Specialists:*

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# CNS
## *Adaptive Driving Solutions*

## PHYSICIAN'S REPORT OF MEDICAL STATUS FOR DRIVING
## PHYSICIAN'S ORDERS FOR ADAPTIVE DRIVING

The Center for Neurorehabilitation Services requests the following information prior to a driver evaluation with this client. Please make any comments that may relate to driving potential. All of the following information is confidential and will not be released to any agency or person without written, informed consent from the applicant.
**PLEASE FAX OR MAIL THIS FORM PRIOR TO THE DRIVING EVALUATION ON** _____. Thank you.

**Medical History**

DoB:

Name: _____ ICD10 Codes: _____ Date of Onset: _____

Date of last hospitalization from _____ to _____. Where? _____

Please check all items below that apply. Provide additional information/comments that relate to driving.

☐ Medications: _____

☐ Difficulty managing medications independently

☐ Concerns about cognition

☐ Difficulty managing personal finances

☐ History of blackouts, seizures _____ Explain: _____
Date of last blackout/seizure: _____

☐ Upper extremity problems: ☐ Right ☐ Left ☐ Bilateral
- ☐ Paresis
- ☐ Sensation problems
- ☐ Decreased range of motion
- ☐ Limitation in strength
- ☐ Position sense
- ☐ Muscle tone

☐ Lower extremity problems: ☐ Right ☐ Left ☐ Bilateral
- ☐ Paresis
- ☐ Sensation problems
- ☐ Decreased range of motion
- ☐ Limitation in strength
- ☐ Position sense
- ☐ Muscle tone
- ☐ History of recent falls

☐ Mobility devices required: _____

☐ Vision problems: _____

☐ Hearing problems: _____

Driving Potential: ☐ Excellent ☐ Good ☐ Fair ☐ Questionable ☐ History of recently getting lost while driving.

**This completed form will serve as physician's orders for a driving evaluation.**
Note: We will contact you with the results of the driving evaluation so that you can provide the final determination of _____ (client's name) driving status. We will ask the client to follow up with you directly.

Date: _____

_____ _____
Physician's Signature Printed Physician's Name

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