MossRehab Driving Program **P: 215-886-7706** **201 Old York Road – Suite 203**
Physician Referral Form **F: 215-886-7709** **Jenkintown, PA 19046**

****All Fields Required****

Preferred Scheduling Location:

☐ Jenkintown, PA ☐ Wilmington, DE

Patient Demographics:

To be completed by Patient or Referring Physician

****All Fields Required****

☐ Active License ☐ Suspended License ☐ No License ☐ Permit License Number: _____

Patient's Name: _____ Date of Birth: _____

Phone Number: _____ Additional Phone Number: _____

Street Address: _____ Last 4 of SSN: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact: _____ Phone Number: _____

Who should we contact to schedule? ☐ Patient ☐ Emergency Contact ☐Other: _____

Physician Referral / Medical History:

To be completed by **Referring Physician:** In order to assist us in performing a driver's evaluation on the above-named individual, please complete the medical information requested below. Please return this form to the above address or fax to 215-886-7709. You will receive a copy of the results of this evaluation.

****All Fields Required****

Referring Physician's Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Diagnosis: _____ ICD 10: _____

Date of Onset: Date of last seizure: ☐ Not Applicable

Is the patient on medication which may interfere with ability to drive?

☐ No ☐ Yes - If YES, please provide a list

Are you aware of any other medical/visual condition which may affect this person's ability to drive?

☐ No ☐ Yes - If YES, specify:

Does the person use any adaptive devices for mobility?

☐ No ☐ Yes - If YES, specify:

Can the person transfer into/out of a sedan?

☐ No ☐ Yes

Does the person have any weakness in their upper/lower extremities?

☐ No ☐ Yes - If YES, specify:

Does the person have any sensation loss in feet/legs?

☐ No ☐ Yes - If YES, specify:

Does the person currently use any adaptive driving equipment?

☐ No ☐ Yes - If YES, specify:

Physician's Signature: _____ Date Completed: _____

Physician Print Name: _____

License Number: _____ NPI Number: _____

****All Fields Required****