

REFERRAL FORM FOR DRIVING THERAPY

To the Referring Agent: Answering the following questions will allow us to provide a more complete evaluation of the Patient's needs as driver and/or passenger. **Your signature at the bottom will be considered a written authorization for a driving evaluation, and treatment/remediation, if indicated, in accordance with submission through HCAI.** We will send you the results of the Initial Assessment, as well as all Progress and Final Assessments and Reports throughout Recovery Program. Thank you.

PLEASE RETURN TO:

Challenger Rehab On Wheels Ltd

ATTN: Melissa Challenger, B.A., D.T.(Hon), D.C.A.

Website: www.challengerrehab.net

Email: melissa@challengerrehab.net

Fax:(519) 624-5598 Office: 866-966-5637

PATIENT INFORMATION

Patient's Name: _____ Home Phone: _____

Address: _____ Work/Cell Phone: _____

Email Address:

Diagnosis/Disability: _____ **Onset/M.V.C.:**

D.O.B. _____ **Policy#:** _____ **Claim#:**

PLEASE ADVISE IF INSURANCE COMPANY HAS BEEN NOTIFIED OF THIS REFERRAL:

Insurance Company & Referring Agent Information: (please complete & print clearly)

Funding Agency/Insurance Company:

Address:

Contact Person: _____

Phone: () _____

Fax: () _____

Email:

Referring Agent's Name and Title:

Referring Agency and Address:

Phone: () _____

Fax: () _____

Email: _____ **HCAI/REGISTRATION # (REQUIRED):**

Signature: _____

PATIENT'S NAME: _____ **PATIENT'S PHONE:**

Professional Opinion: comments or observations regarding this Patient. Please list details of reason for referral and any relevant information which may assist in our assessment/program:

Has the client returned to work, or is a return to work to be addressed:

Please list relevant injury codes:

What in-vehicle issues need to be addressed:

Is this client predominantly a Minor Injury or a Major Injury, as referred to in the Injury Guidelines:

Relevant Medical History:

(Please attach medical history if applicable)

PLEASE CIRCLE IF APPROPRIATE & ADD COMMENTS AS NECESSARY:

- **Visual limitations?** (*acuity, double vision, night myopia etc.*)
- **Seizure Disorder** (with date of last seizure?)
- **Dizziness?** Cardiac precautions?
- **Orthopaedic concerns that may impact driving?**
- **Current adaptive devices in vehicle, if known?**
- **Could present medications influence driving?**
- **Current medications:**
- **Have you reported this Patient to the Ministry of Transportation?**
- **What, if any, foreseeable barriers to treatment?**

Thank you for your referral,

**Christopher Challenger, B.A.Kin(H), B.Ed., D.T.(H), N.R.T., O.C.T.
Principal Driving & Rehabilitation Therapist
Challenger Rehab On Wheels Inc.**