Alberta Health Services

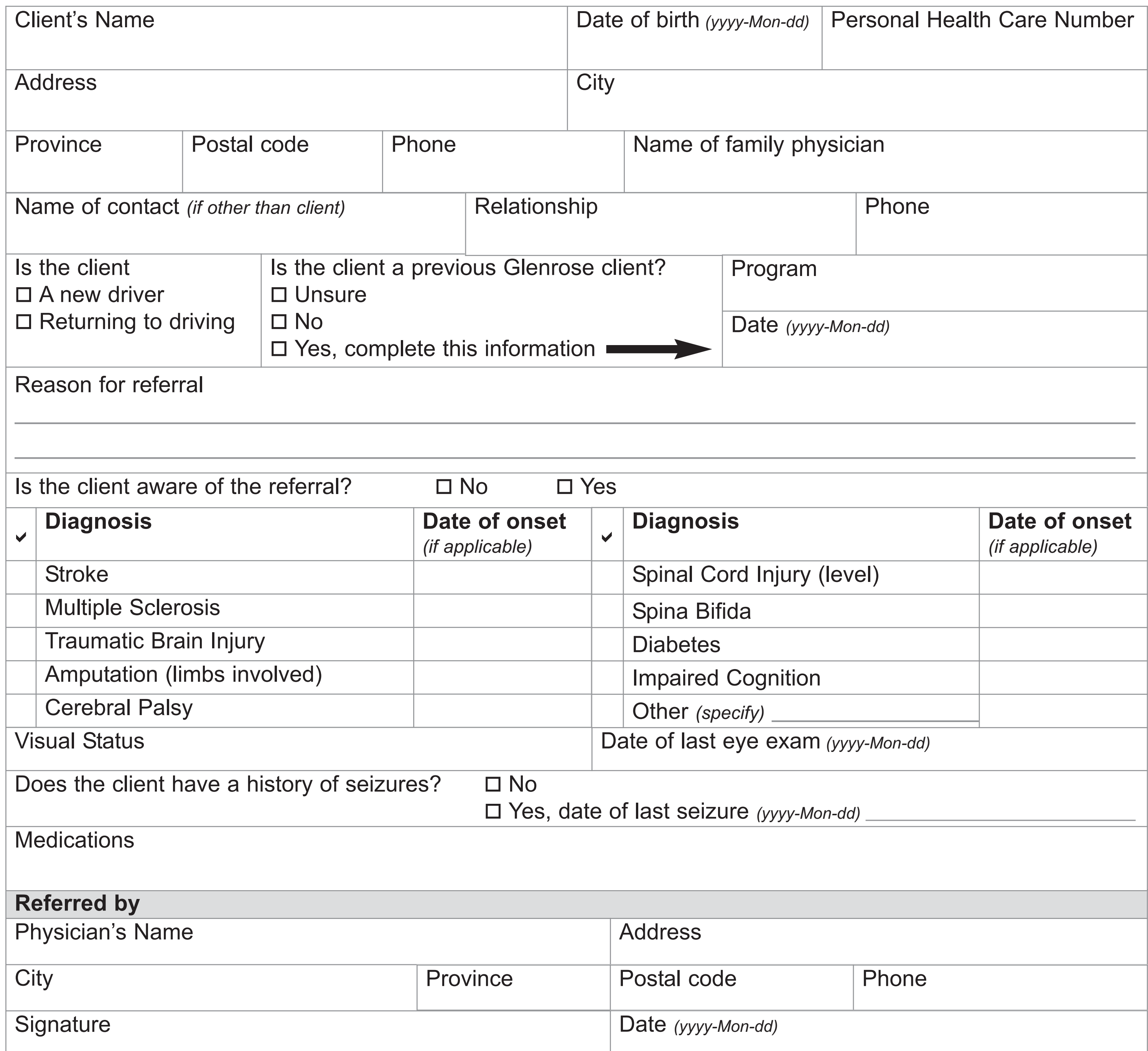
Affix patient label within this box.

Driver Evaluation and Training Service Referral

In order to complete this driver evaluation, our clients **must** have permission of Alberta Transportation, Driver Fitness and Monitoring. If the client has not received permission, please complete a Medical Examination for Motor Vehicle Operators found on-line at http://www.servicealberta.gov.ab.ca/pdf/TRANS3050.pdf before completing this referral.

Has a driver's medical been submitted to Alberta Transportation, Driver Fitness and Monitoring? ☐ Yes ☐ No

Please complete all sections of this form, print, sign, and return with relevant reports *(i.e. Physiatrist, Neuropsychology, Ophthalmology)* by fax to Occupational Therapy Services at **780.735.7946.**



Client's Name	Date of birth *(yyyy-Mon-dd)*	Personal Health Care Number

Address	City

Province	Postal code	Phone	Name of family physician

Name of contact *(if other than client)*	Relationship	Phone

Is the client	Is the client a previous Glenrose client?	Program
☐ A new driver ☐ Returning to driving	☐ Unsure ☐ No ☐ Yes, complete this information →	Date *(yyyy-Mon-dd)*

Reason for referral

Is the client aware of the referral? ☐ No ☐ Yes

✓	Diagnosis	Date of onset *(if applicable)*	✓	Diagnosis	Date of onset *(if applicable)*
	Stroke			Spinal Cord Injury (level)	
	Multiple Sclerosis			Spina Bifida	
	Traumatic Brain Injury			Diabetes	
	Amputation (limbs involved)			Impaired Cognition	
	Cerebral Palsy			Other *(specify)* ____________	

Visual Status	Date of last eye exam *(yyyy-Mon-dd)*

Does the client have a history of seizures? ☐ No ☐ Yes, date of last seizure *(yyyy-Mon-dd)* ____________

Medications

Referred by

Physician's Name		Address	
City	Province	Postal code	Phone
Signature		Date *(yyyy-Mon-dd)*	

CR 306(2011-02)