DriveFit Referral Form

Please fax completed forms to 1-877-807-4669

Date of Referral ______________________

Client Information

Name DOB (DD/MM/YYYY): Phone:

Address: City: Postal Code

Valid driver's licence? Yes No Received Driver's Medical Examination Form from RoadSafetyBC? Yes No

Alternate Contact:

Name Relationship to Client: Phone number

Service requested

Determine driver fitness:

- DriveFit Virtual Screening* Includes: MoCA , SIMARD-MD, CDT, Trails B
- DriveFit In-Clinic Evaluation include DriveABLE*
- DriveFit On-Road Evaluation include DriveABLE*

*If cognitive concerns

Support for returning to driving:

- Driver anxiety
- Post-Injury
- Post-Concussion
- Post medical event/surgery

Referred by:

Name: Phone: Fax:

Choose one:

Family physician NP Specialist PT OT Other: ___________________________

Please inform patient there is a fee for this service

3rd Party Insurance (if applicable)

ICBC WSBC Other: ______________________ File/Claim#:_____________________________________

Contact: ____ Phone: ______________________ Fax: _________________________

Email: ____

Reason for referral

Diagnosed or suspected of:

- Alzheimer's or other dementia
- Parkinson's Disease
- Multiple Sclerosis
- Other neurodegenerative disease
- Cardiac disease

Recent:

- CVA
- MI
- Surgery
- Brain injury/concussion
- Other injury (explain in comments)

Date of event/injury:______________________

Cognitive screen results (if available):

SIMARD-MD ____/120

MoCA ____/30

Global Deterioration Scale: Stage _____

Other:

Symptoms and considerations (check all that apply)

Weakness:	Rt Leg	Lt leg	Rt arm	Lt arm	General
Paralysis:	Rt Leg	Lt leg	Rt arm	Lt arm	
Amputation:	Rt Leg	Lt leg	Rt arm	Lt arm	

Other Motor impairment:

Cognitive impairment

Visual impairment

Other sensory impairment:

Comments