Shepherd Center

Center for Assistive Technologies Driving Referral Form

Please complete the below sections, including the diagnosis, and sign.
Please attach the most recent medical history and physical or chart note.
(Not completing the form/providing chart note may delay scheduling)

Client Information

Name: _____ Date of Birth:_____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Email: _____

☐ OT Evaluation and Treatment for Assistive Technology Services

Diagnosis and/or ICD-10 Code (required): _____

Insurance Type: ☐ Medicare ☐ Medicaid ☐ Private Insurance: _____

☐ VR ☐ VA

Driving Evaluation and Rehabilitation

☐ Driver's License ☐ Learner's Permit License/Permit #: _____ Expiration: _____

Has the client has a seizure or episode within the last year? ☐ Yes ☐ No If yes, date: _____

Current medications that may affect safe driver: _____

Do you recommend any driving restrictions? ☐ Yes ☐ No

If yes, please specify: _____

Referral Source

Provider Name: _____ Phone: _____

Fax: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Provider Signature: _____ Date: _____

Appointment will not be scheduled without signature.

Have this form faxed to 404-350-7356. If you are not contacted by scheduling after **two business days**, please call 404-355-1144.