



## REFERRAL

### Functional Driver Assessment-Medical

#### CLIENT INFORMATION:

Name: \_\_\_\_\_

Driver's License #: \_\_\_\_\_

Class: \_\_\_\_\_

Expiry: \_\_\_\_\_

Ministry of Transportation File #: \_\_\_\_\_

Status of Driver's License: Valid      Suspended

Due date to submit Functional Assessment Report: \_\_\_\_\_

Medical Diagnosis/Reason for Medical Suspension or Review: \_\_\_\_\_

Do you wear corrective eye lenses: Yes      No

DOB: \_\_\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_ Unit #: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Contact #: \_\_\_\_\_

EMAIL: \_\_\_\_\_

#### Medical TEAM:

*Family Physician Name:* \_\_\_\_\_

Contact #: \_\_\_\_\_

Address: \_\_\_\_\_

FAX #: \_\_\_\_\_

*Treating Specialist Name:* \_\_\_\_\_

Contact #: \_\_\_\_\_

Address: \_\_\_\_\_

FAX #: \_\_\_\_\_

*Other-Name & Designation:* \_\_\_\_\_

Contact #: \_\_\_\_\_

Address: \_\_\_\_\_

FAX #: \_\_\_\_\_

Green Light Driver Therapy

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