GREEN LIGHT
DRIVER THERAPY

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#: _____