DriveLab
Driver Assessment & Rehabilitation

Referral Date: _____

DriveLab Inc. File #: _____

Functional Driving Assessment Referral Form
(Self-Payer/MTO)

Client's Last Name:_____ **First Name:** _____

Address: _____

City: _____ Postal Code: _____ Date of Birth: _____

Phone #: _____ Cell #: _____ Other Contact: _____

Driver's Licence #: _____**Expiry Date:**_____

MTO Reference #:_____

☐ **Valid** ☐ **Suspended** **Date of Suspension:** _____ **Date Report due at MTO:**_____

Medical Diagnosis: _____

Referral Source Name: _____Phone #: _____

(client or Health Care Professional) Fax #: _____

Company/Address:_____

Physician (GP):_____

Phone #:_____ Fax #: _____

Address:_____

Physician (Spec.):_____

Phone #:_____ Fax #: _____

Address:_____

FOR OFFICE USE ONLY:

Appointment Date: _____
O.T.: _____ Time: _____
C.D.I.: _____ Time: _____
FAC Location: _____
Informed Client of: ☐ Cost $_____ ☐ Eye Form ☐ Release of Medical Information Form