Driver Assessment & Training
Toll Free: 1-877-397-1035
Phone: 416-398-1035
Fax: 1-855-704-4080

Saint Elizabeth
Well beyond health care

Driver Assessment & Training

MEDICAL REFERRAL FORM

Patient's Last Name: First Name:

Address:

City: Postal Code:

D. of B. License Suspension: ☐YES ☐ NO

Home Phone: Business Phone:

Diagnosis (es):

Has patient been informed of diagnosis (es): ☐YES ☐ NO

Date of Onset:

Current Medical Status: ☐ Stable ☐ Progressive ☐ Fluctuating ☐ In remission
Please indicate degree or stage of impairment/diagnosis:
Comments:

Has the Ministry of Transportation been informed of diagnosis? ☐YES ☐ NO
If Yes, Date MTO informed: _____ (Please enclose copy of letter)

Has Physician asked patient not to drive? ☐YES ☐ NO

Vision (not required if vision report attached): Date Vision Assessed:_____
Visual Acuity: Left _____ Right: _____ Both: _____
Horizontal Peripheral Fields: Left _____ Right: _____ Both: _____

Cognition (include any relevant test scores or attach reports):

Medications:

Side Effects:

Comments / Concerns related to driving:

I confirm that the above named patient has no contra-indications that would prohibit participation in the Driver Evaluation and Driver Training if recommended.

Physician Name: _____

Address:_____

Phone: ( ) _____ Fax: ( ) _____

Physician Signature: _____ Date: _____

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