Avenues **D**riving
Rehabilitation **P**rogram

Driving Program Patient Information

Name: _____ Phone: _____

Address: _____ County: _____

City: _____ State: _____ Zip Code: _____

DOB: ___/___/_____ SSN: _____ – _____ – _____ Sex: _____ Race: _____ Marital Status: _____

Emergency Contact Information

Name: _____ Phone: _____

Address: _____ Relationship: _____

Name: _____ Phone: _____

Address: _____ Relationship: _____

Legal Guardian/Power of Attorney: _____ Phone: _____

Address: _____ Relationship: _____

Medical Diagnosis: _____ Onset: _____

Physician Name: _____ Phone: _____

Address: _____

Background Information

Why are you being referred to the Driver's Evaluation Program? _____

_____

Do you have any of the following? (Please check the "Yes" or "No" column for each item.)

		YES	NO
1.	Right arm weakness/paralysis	_____	_____
2.	Left arm weakness/paralysis	_____	_____
3.	Right leg weakness/paralysis	_____	_____
4.	Left leg weakness/paralysis	_____	_____
5.	Memory problems	_____	_____
6.	Peripheral vision deficits	_____	_____
7.	Double vision	_____	_____
8.	Blurry vision	_____	_____
9.	Hearing impairment	_____	_____
10.	Difficulty reading	_____	_____
11.	Difficulty speaking or understanding others	_____	_____
12.	Can you walk?	_____	_____
13.	Do you use a cane?	_____	_____
14.	Do you use a walker?	_____	_____

Height _____ Weight _____

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Please list past medical history:

_____

_____

Please include a list of your medications:

_____

_____

Have you had a seizure in the last six months? Yes _____ No _____

If "yes" please indicate the date of your last seizure: _____

Have you participated in therapies, OT, PT or Speech?
If so, are you currently in therapy? When was discharge?
Are you currently driving? Yes _____ No _____

If "no" approximately how long has it been since you last drove? _____

Have you had any accidents or tickets in the last 5 years? Yes _____ No _____

If "yes" please explain. _____

Have you ever had your license revoked? Yes _____ No _____

If "yes" please explain: _____

Driver's License Number or Permit Number: _____

Restrictions and Expiration Date: _____

Primary Vehicle: Year: _____ Make: _____ Model: _____

PLEASE ANSWER THE FOLLOWING ONLY IF YOU ARE CURRENTLY USING A WHEELCHAIR

1. What type of wheelchair do you use? Manual _____ Power _____
2. Can you transfer independently from your wheelchair into and out of a vehicle? Yes _____ No _____
3. Can you independently load and unload your wheelchair into and out of a vehicle? Yes _____ No _____

The preceding information is true to the best of my knowledge. I understand that falsification of any of the above information would prohibit my participation in the driving program.

Signature: _____ Date: _____