***A**venues **D**riving*
***R**ehabilitation **P**rogram*

Phone: 913-272-1710
Fax: 913-369-4498

Patient Name: _____ Phone Number: _____

Diagnosis: _____

Does the patient have any of the following (if yes, explain):

Yes	No	
_____	_____	Medical diagnosis affecting driving ability.
		_____
		_____
_____	_____	Taking medications which may adversely affect patient's fitness in operation of a motor vehicle?_____
		_____
_____	_____	Seizure Disorder: if yes, date of last episode: _____
_____	_____	Motor vehicle crashes/incidents

My signature indicates that I am authorizing this patient to have a Driver's Evaluation and Training, if needed. Furthermore, if the patient has a progressive illness, and it is deemed appropriate, re-evaluation is also authorized.

_____ _____
Physician's Signature Date

Physician's Name (Printed): _____

Physician's Address: _____

Physician's Phone Number: _____

Physician's Fax Number: _____

NPI #: _____

PLEASE COMPLETE ALL AREAS OF THIS MEDICAL PRESCRIPTION FORM .

Thank you for your referral.