Patient Name:

Phone:

Diagnoses:

Does the patient have any of the following?

Medical diagnoses affecting driving ability Yes [ ]  No [ ]

Taking medications that adversely affect driving ability Yes [ ]  No [ ]

Seizure disorder Yes [ ]  No [ ]

Vision concerns Yes [ ]  No [ ]

Cognitive concerns Yes [ ]  No [ ]

Motor vehicle crashes or incidents Yes [ ]  No [ ]

**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 name: Date:

Physician’s address:

Physician’s phone number: