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: