



## Limitless Living Solutions

### DRIVING Evaluation Referral

1. Please complete and return this order request for an Occupational Therapy Driving Evaluation & Treatment for this patient.

First Name:

Last Name:

Date of Birth:

Home Phone:

Best Contact Name & Number (if not client)

Referring Physician

Contact

Reason for referral

Medical Diagnosis

### Questions for Referring Physician

2. Is the patient on medications that may interfere with fitness to drive? YES or NO

If yes, please explain:

3. Are you aware of any other medical/visual conditions that may affect this person's fitness to drive? YES or NO

If yes, please explain:

4. Do you approve this patient's participation in OT driving evaluation & treatment? YES or NO

If yes, the order states: "Occupational Therapy Driving Evaluation and Treatment."

5. Physician Signature:

Date:

Physician Name (please print):

License Number:

NPI:

**Please fax the order to Limitless Driving Solutions at  
(816) 300-9681.**