PAM HEALTH REHABILITATION HOSPITAL OF OVERLAND PARK

THE UNIVERSITY OF KANSAS HOSPITAL PARTNERSHIP

Phone: 913-967-5245
Fax:913-499-6349

Patient Name: ______________________ Phone Number: ______________________
DOB: ______________________ Best Contact Name: ______________________
Address: ____

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 an OT Evaluation and Treatment incorporating 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.