PAM Health Rehabilitation Hospital of Overland Park
The University of Kansas Hospital Partnership

Driving Program Patient Information

Name: _____ Phone: _____

Address: _____ County: _____

City: _____ State: _____ Zip Code: _____

DOB: ___/___/_____ SSN: ___–___–_____ Sex: _____ Race: _____ Marital Status: _____

Emergency Contact Information

Name: _____ Phone: _____

Address: _____ Relationship: _____

Name: _____ Phone: _____

Address: _____ Relationship: _____

Legal Guardian/Power of Attorney: _____ Phone: _____

Address: _____ Relationship: _____

Medical Diagnosis: _____ Onset: _____

Physician Name: _____ Phone: _____

Address: _____

Background Information

Why are you being referred to the Driver's Evaluation Program? _____

_____

Do you have any of the following? (Please check the "Yes" or "No" column for each item.)

		YES	NO
1.	Right arm weakness/paralysis		
2.	Left arm weakness/paralysis		
3.	Right leg weakness/paralysis		
4.	Left leg weakness/paralysis		
5.	Memory problems		
6.	Peripheral vision deficits		
7.	Double vision		
8.	Blurry vision		
9.	Hearing impairment		
10.	Difficulty reading		
11.	Difficulty speaking or understanding others		
12.	Can you walk?		
13.	Do you use a cane?		
14.	Do you use a walker?		

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Height _____ Weight _____

Please list past medical history:

_____

_____

Please include a list of your medications:

_____

_____

Have you had a seizure in the last six months? Yes _____ No _____

If "yes" please indicate the date of your last seizure: _____

Have you participated in therapies, OT, PT or Speech?
If so, are you currently in therapy? When was discharge?
Are you currently driving? Yes _____ No _____

If "no" approximately how long has it been since you last drove? _____

Have you had any accidents or tickets in the last 5 years? Yes _____ No _____

If "yes" please explain. _____

Have you ever had your license revoked? Yes _____ No _____

If "yes" please explain: _____

Driver's License Number or Permit Number: _____

Restrictions and Expiration Date: _____

Primary Vehicle: Year: _____ Make: _____ Model: _____

PLEASE ANSWER THE FOLLOWING ONLY IF YOU ARE CURRENTLY USING A WHEELCHAIR

1. What type of wheelchair do you use? Manual _____ Power _____
2. Can you transfer independently from your wheelchair into and out of a vehicle? Yes _____ No _____
3. Can you independently load and unload your wheelchair into and out of a vehicle? Yes _____ No _____

The preceding information is true to the best of my knowledge. I understand that falsification of any of the above information would prohibit my participation in the driving program.

Signature: _____ Date: _____