

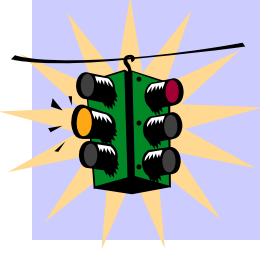
BRAINTREE REHABILITATION HOSPITAL OUTPATIENT CLINIC

250 Pond Street, Braintree, MA 02184

(781) 348-4017 Fax: (781) 356-4222

DRIVING EVALUATION PRESCRIPTION

FIVESTAR ★ QUALITYCARE



In order to properly evaluate your patient, please provide us with a brief history and fax back to us. This form also serves as your referral for therapy services

Patient Name: _____ D.O.B. _____ Date: _____

Patient Address: _____

Telephone: _____ Insurance: _____

Diagnosis: _____ Approx. Onset: _____

Pertinent Medical History:

Current Drivers License: Yes _____ No _____

Please indicate if any of the following medical issues are pertinent:

Yes	No		Yes	No	
___	___	Seizures: Most recent seizure date: _____	___	___	ETOH Abuse
___	___	Medications (i.e. sedatives)	___	___	Visual Deficits
___	___	Behavioral Problems	___	___	Poor Endurance

Other: _____

In order to streamline the evaluation when appropriate, please identify the areas of concern you wish to have evaluated:

Yes	No	
___	___	Physical Issues / Adaptations
___	___	Vision / Perception
___	___	Cognition

Is the patient currently receiving therapy services? _____ Where? _____

Is the patient involved with the Massachusetts Rehabilitation Commission?: ___ Yes ___ No

Referring Physician: _____

Address: _____

Phone: () Fax: ()

Physician Signature: _____ Date: _____

My signature authorizes this treatment to be medically necessary