St. Lawrence Rehabilitation Center

Driver Rehabilitation Intake Form

PLEASE FAX TO: 609-896-0698 ATTENTION: Driving Program Coordinator

CLIENT NAME: ____________________ DOB: ____________ SEX: M F

CLIENT ADDRESS: ____________________ PRIMARY PHONE: ____________

____________________ OTHER PHONE: ____________

DOES CLIENT CURRENTLY HAVE A VALID DRIVER'S LICENSE OR PERMIT (circle one)? ☐ Yes ☐ No

HAS CLIENT HAD A MOTOR VEHICLE ACCIDENT IN THE LAST SIX MONTHS? ☐ Yes ☐ No

HAS CLIENT RECEIVED FORMS FROM THEIR STATE MOTOR VEHICLE MEDICAL UNIT? ☐ Yes ☐ No

DRIVER'S LICENSE NUMBER: ____________ STATE: ________ EXPIRES: ________

FAMILY INFORMATION/EMERGENCY CONTACT:

IS THIS PERSON THE PRIMARY CONTACT FOR SCHEDULING SERVICES? ☐ Yes ☐ No

NAME: ____________________

ADDRESS: ____________________

PRIMARY PHONE ____________ Home/Work/Cell OTHER: ____________ Home/Work/Cell

RELATIONSHIP: ☐ Spouse ☐ Child/Grandchild ☐ Professional Caregiver ☐ Friend

☐ Other (Please explain): ____________________

REFERRING PHYSICIAN (Below physician will be contacted to sign a referral to initiate services.)

PHYSICIAN NAME: ____________ PRACTICE NAME: ____________

PHYSICIAN ADDRESS: ____________________

PHYSICIAN PHONE: ____________ PHYSICIAN FAX #: ____________

REASON FOR REFERRAL (check below) DATE OF ONSET OF DIAGNOSIS OR SYMPTOMS: ____________

___CVA ☐ Right sided weakness ☐ Left sided weakness ☐ Vision changes ☐ Speech/language changes

___Head Injury ☐ Mild ☐ Moderate ☐ Severe ☐ Surgical repair or shunt?

___Mild Cognitive Impairment or Dementia

___Other Neurological or Developmental condition (Please specify)

___Vision Issue Explain: ____________________

___Amputee ☐ Right Leg ☐ Left leg ☐ Upper extremity ☐ Prosthetic device

___Other Physical ☐ Right sided weakness ☐ Left sided weakness ☐ Lower extremity weakness ☐ Arm/hand weakness

___Safety Evaluation; No Other Symptoms

___OTHER Please explain:

Was client's injury caused by a motor vehicle accident? ☐ Yes ☐ No Date of Accident: ________

Has the client been hospitalized during the last six months? ☐ Yes ☐ No Dates: ____________

Significant Medical History/Chronic conditions:

___Seizure Disorder	___High Blood Pressure	___ Vision Surgeries (explain below)	___ Asthma
___ Diabetes	___Pacemaker/Defibr.	___ Hard of Hearing	___ COPD
___ Neuropathy	___ Atrial Fibulation	___Currently Pregnant	___ EOTH

OTHER:

Are you allergic to latex? ☐ Yes ☐ No Are you allergic to any medications? If so, please list:

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