ADAPTIVE INDEPENDENCE Missoula

Comprehensive Driving Evaluation Provider Order Form

Please attach a copy of the patient's most recent visit notes along with an updated medication list. Thank you.

Today's Date: _____

Patient Name:_____ DOB:_____ Gender:_____

Address:_____ Phone Number: _____

Primary Diagnosis: _____ Month/Year of Onset: _____

Medical Precautions (ie. Cardiac, Seizure, etc.): _____

Order for [check box(es) that apply]:

- ☐ Comprehensive Driving Evaluation and Treatment
- ☐ Adaptive Equipment Assessment and Order – As Needed
- ☐ Other: _____

History of Seizures? ○ **Yes** ○ **No** | Date of Onset: _____ Date of Last Seizure: _____

Recent coma and/or LOC? ○ **Yes** ○ **No** | Date of Onset: _____ Length of Coma: _____

Pain? ○ **Yes** ○ **No** | Please describe:

Additional pertinent details about patient's mobility, vision, perception, cognition, or behavioral status:

Referring Provider's Name: _____Phone: _____ Fax : _____

Address:_____ Practice Name: _____

In your professional opinion, does this patient have the physical and cognitive skills to safely participate in a comprehensive driving/behind-the-wheel evaluation?

○ **Yes** ○ **No** | Details: _____

Referring Provider Digital or Wet Signature (Full Name and Credentials)

Date of Signature

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