APPIAN WAY REHABILITATION INC

# REFERRAL FORM

Please help us in our efforts to expedite the referral process by providing as much of the following information about your client/ patient as possible. We would also welcome more in-depth documents or summaries, whether formal or informal (e.g. medical, psychological or other reports).

**This patient is being referred for:**

☐ Exposure Program
☐ Driver Competency Assessment

## Client Information

| PREFIX ☐ Mr. ☐ Ms. ☐ Mrs. | FIRST NAME | LAST NAME | DATE OF BIRTH (DD/MM/YYYY) |
|---|---|---|---|
| ADDRESS | | | POSTAL CODE |
| HOME PHONE # | CELL PHONE # | | WORK PHONE # |
| DRIVERS LICENSE | | | EXPIRY |
| DIAGNOSIS / REASON FOR REFERRAL | | | ONSET / MVC DATE |

## Client Medical History

1. Visual impairments? ☐ Yes ☐ No ☐ Unknown

2. Auditory impairments? ☐ Yes ☐ No ☐ Unknown

3. Cognitive impairments? ☐ Yes ☐ No ☐ Unknown

4. Orthopedic concerns? ☐ Yes ☐ No ☐ Unknown

5. Other physical or psychological concerns? ☐ Yes ☐ No ☐ Unknown

Has this client suffered from previous traumas that we should know about?

Is this client taking medications that could affect safe motor-vehicle operation? Please list:

Do you have any other concerns for your patient in completing an in-home assessment, on-road assessment, or in entering into a desensitization program as a driver, passenger, or pedestrian?

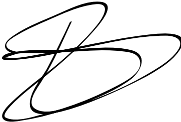
## Insurance Information

| INSURANCE COMPANY NAME | | | |
|---|---|---|---|
| **STREET ADDRESS** | **CITY** | **PROVINCE** | **POSTAL CODE** |
| **INSURANCE ADJUSTER'S NAME** | | | |
| **PHONE #** | **FAX #** | | |
| **CLAIM NUMBER** | **POLICY NUMBER** | | |

## Referrer Information

| REFERRING AGENCY NAME | | | |
|---|---|---|---|
| STREET ADDRESS | CITY | PROVINCE | POSTAL CODE |
| REFERRING AGENT NAME (INCLUDING TITLE AND DESIGNATIONS) | | | |
| PHONE # | FAX # | | |
| REFERRER SIGNATURE | DATE | | |

**Thank you for your referral,**



Jeff McKay, B.A. (spec. Hons), DT, DCA
Director of Appian Way