DRIVER REHABILITATION SERVICES, P.A.
PO BOX 448 | McLeansville, NC 27301
OFFICE: 336-697-7841 | FAX: 336-697-7842
TOLL-FREE NUMBER: 1-888-888-0039

Physician's Office Referral

FAX form along with recent medical data to # ***336-697-7842***

The patient will be contacted to discuss services.

Patient Information:

First and Last Name: _____

Address/City/State/Zip: _____

Phone Numbers: Home_____ Work_____ Mobile_____

Date of Birth: _____ Current Age: _____ Patient is: Male _____ Female _____

Does patient have a valid driver's license or permit? Yes_____ No_____ unknown_____

Reason for Referral (note medical challenges client may be experiencing that could compromise driving):

_____

_____

_____

_____

_____

Does patient use mobility aids? No ____ Yes ____ Cane____ Walker____ Wheelchair____ Prosthesis_____

Has patient requested doctor complete DMV Medical Evaluation Forms? Yes_____ No_____Unknown_____

If the patient is cognitively impaired or is a teen driver who has a family member helping secure services list family member name and contact #:_____

Physician Information:

Physician First and Last Name: _____

Medical Practice: _____

Address/City/State/Zip: _____

Office Phone: _____ Office Fax: _____

Name & Contact number of person submitting referral: _____