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

Teen Driver Referral

FAX Form along with Restricted Instruction permit if available to ***336-697-7842.***
The appropriate person will be contacted to discuss services.

Teen Information:

First and Last Name: ____

Address/City/State/Zip: ____

Phone Numbers: Home__________________ Work__________________ Mobile____________________

Date of Birth: ________________ Current Age: __________ Client is: Male _______ Female _______

Has Teen completed classroom driver's education? Yes_______ No_______ Unknown__________

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

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

Is client involved in DMV Medical Evaluation Program? Yes________ No_________ Unknown__________

Referring Source Information:

Referral Source First and Last Name: ____

Relationship to Teen: ____

Referral Source Agency/School System (if applicable):____

Address/City/State/Zip: ____

Email: ________________________________ Phone: ____________________ Fax: ___________________

Please contact (Place x in appropriate section): Client directly__________ Me as referring source__________