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

Worker's Compensation Client Referral

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

A cost estimate will be sent to the Case Manager & Adjuster.

Client Information:

First and Last Name: ____

Address/City/State/Zip: ____

Phone Numbers: Home__________________ Work____________________ Mobile___________________

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

Does client 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):

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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__________

Worker's Compensation Information:

Case Manager First/Last Name & Title: ____

Company: ____

Address/City/State/Zip: ____

Email: ______________________________ Office Phone: _______________ Office Fax: ______________

Adjuster First and Last Name: ____

Worker's Compensation Carrier: ____

Address/City/State/Zip: ____

Email: ______________________________ Office Phone: _______________ Office Fax: ______________