Main Line Health®
Bryn Mawr Rehab

DRIVER REHAB PROGRAM REFERRAL FORM

DRIVER REHAB PROGRAM
414 Paoli Pike
Malvern, PA 19355

TEL **484.596.6000**
FAX **484.596.5449**
mainlinehealth.org/driver-rehab

PATIENT DEMOGRAPHICS
**** All fields required ****

Patient's Name: ______________________ DOB: ____/____/________ Phone: _______-_______-________

Street Address: ______________________ City: ________________ State: _______ Zip: ____________

Emergency Contact: ____________________ Relationship: ______________ Phone: _______-_______-________

Who should be contacted to schedule? ☐ Patient ☐ Emergency Contact ☐ Other: ______________________

License Status: ☐ Active License ☐ Suspended License ☐ No License ☐ Permit License Number: ________________

PROVIDER REFERRAL/ MEDICAL HISTORY
**** All fields required ****

Diagnosis/Reason for Referral: ______________________ Onset: ____________ ICD 10 Code: ____________

Significant Past Medical History (Please attach history if available): ______________________________

☐ YES ☐ NO **Visual Limitations** (e.g. diplopia, acuity: minimum 20/40 distant, or 20/60 daytime-only **required**)

☐ YES ☐ NO **Visual Field Impairment** (Note: A minimum of 120° of vision at the horizontal meridian is **required**)

☐ YES ☐ NO **Seizure Disorder** (Minimum 6 month seizure-free) Date of Last Episode (if applicable): _____/_____/________

☐ YES ☐ NO **Dizziness or Syncope** Please indicate by circling. Date of Last Episode (if applicable): ____/_____/_________

☐ YES ☐ NO **Medications which influence driving** Please list: ______________________________

☐ YES ☐ NO **Has Patient been reported to PennDOT or other DMV?**

☐ YES ☐ NO **Does this patient use adaptive devices for driving?** Please list: ______________________

☐ YES ☐ NO **Can the patient transfer into/out of a sedan?** Comments: ______________________

Completed referral with signature will serve as a written prescription for a driving evaluation and training, if indicated.
Evaluation/ progress reports to be provided following completion of services. Please call 484-596-6000 with questions. Thank you for your referral.

Provider's Signature: ______________________________ Date Completed: ______/______/____________

Provider's Name: ______________________________ License Number: ____________________

Street Address: ______________________ City: ________________ State: _______ Zip: ____________

Provider Phone: _______-_______-________ Provider Fax: _______-_______-________