Providence
HEALTH CARE

☐ Holy Family Hospital
☐ Mount Saint Joseph Hospital
☐ St. Paul's Hospital
☐ Youville Residence

St. Vincent's Hospitals
☐ Brock Fahrni
☐ Langara

REFERRAL FOR DRIVER ASSESSMENT

All items in this section MUST be completed for the referral to be processed.

Patient Surname: _____ Patient First Name: _____

Date of Birth: (month, day, year) _____ Age: _____

Address: _____

_____ Telephone: _____

PHN: _____ Family Physician: _____

Contact: (if other than patient) _____

Relationship: _____ Telephone: _____

REASON FOR REFERRAL: _____

☐ Motor Vehicles has requested an assessment

Diagnoses: (include date of onset if appropriate)

☐ CVA ☐ Diabetes ☐ Mental illness (please specify) _____
☐ Parkinson's ☐ Cataracts ☐ Amputation (please specify) _____
☐ Dementia ☐ Impaired Vision
☐ Impaired Cognition ☐ Other: _____

Visual Status: (if known) _____

History of seizures: _____

Medications: _____

_____

Medical contraindications for driving: _____

Medical Reports attached: (if available)

☐ Ophthalmology ☐ Physiatry ☐ Occupational Therapy
☐ Neuropsychology ☐ Neurology ☐ Documentation from Motor Vehicles
☐ Other: _____

Referred by:

_____ _____
Physician Signature Date

_____ _____ _____
Printed Name Telephone Number Fax Number

Please return completed referral to: **Holy Family Hospital** 7801 Argyle Street, Vancouver, BC V5P 3L6
Phone: 604-322-2617 **Fax: 604-321-6886**