



## DRIVING PROGRAM REFERRAL/PRESCRIPTION

To assist us in performing a driving/community mobility evaluation, please complete the following information:

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Drivers License Number: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Night Phone: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Date of Onset: \_\_\_\_\_

Seizure History: History of seizures Yes  No

If yes, per NJ Motor Vehicle Commission Statute, has this person been seizure free for the minimum of 1 year? Yes  No

Is there any history of loss of consciousness, blackout, vertigo, dizziness, altered vision or related symptoms Yes  No

Do any of the current medications have the potential to interfere with the ability to drive?

Yes  No  if yes, specify \_\_\_\_\_

### PERScription FOR DRIVING/COMMUNITY MOBILITY EVALUATION

Physician's Name: \_\_\_\_\_

License number: \_\_\_\_\_ UPIN # \_\_\_\_\_

Address: \_\_\_\_\_

Phone number: \_\_\_\_\_ Fax number: \_\_\_\_\_

Signature: \_\_\_\_\_

To contact St Joseph's Wayne Hospital Driving Program, call: **973-956-3360**

Please return this form to St Joseph's Wayne Hospital, Rehabilitation Medicine Department  
\* 224 Hamburg Turnpike \* Wayne \* NJ \* 07470 or Fax 973-389-4011

*...you will receive a copy of the results of this evaluation...*