

TRANSPORTATION SOLUTIONS
Evaluation Request Form

This form must be filled in completely by the requesting physician's office and faxed to: (814) 833-2301 phone, **(814) 833-9230 fax**

Request from the office of: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax: _____

Diagnosis: _____

Reason for Referral: *Occupational Therapy Driving Evaluation
& treatment as indicated*

Physician's Signature: _____ **Date** _____

Patients Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Alternate Phone #: _____

Drivers License #: _____ Date of Birth: _____

Wears(circle all that are appropriate):Contacts Glasses Hearing Aid

Mobility(circle all that are appropriate):Cane Walker Wheelchair

Please type or print a list of all medications being taken along with their purpose & attach it with this fax.

We will bill their medical insurance