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Providence HEALTH CARE

HOLY FAMILY HOSPITAL
DRIVER REHABILITATION REFERRAL

Referral Other

Holy Family Hospital - 7801 Argyle Street, Vancouver, BC **Phone: 604-322-2653**

Incomplete referrals will not be processed.

Patient Surname: _____ Patient First Name: _____

Date of Birth: (dd/mmm/yyyy) _____ PHN: _____

Address: _____

Telephone: _____ Alternate contact number: _____

Language: ☐ English ☐ Other: _____ Family Physician: _____

Contact: (if other than patient) _____

Relationship: _____ Telephone: _____

Diagnoses/Medical Conditions: (include relevant dates and functional status)

_____

_____

☐ **Consults attached:** (e.g. ophthalmology, occupational therapy, physiatry, RoadSafetyBC letters, etc.)

Mobility Status: ☐ Ambulatory ☐ Manual wheelchair ☐ Power wheelchair ☐ Scooter ☐ Other: _____

History of seizures: ☐ No ☐ Yes (details) _____

Precautions: (AROs, Restrictions, Aggression risk) _____

Medications: _____

_____

Has a Driver's Medical or other notification been made to RoadSafetyBC (Motor Vehicles)? ☐ No ☐ Yes (date) _____

Has a Driver's Medical Exam been requested by RoadSafetyBC? ☐ No ☐ Yes

Has RoadSafetyBC requested a Functional Driving Evaluation? ☐ No ☐ Yes (please include letter)

Has patient previously had a Functional Driving Evaluation? ☐ No ☐ Yes

If yes, Date: _____ Location: _____

Assessment results: _____

Does patient have a valid driver's license: ☐ No ☐ Yes

Funding Source: ☐ Self ☐ Other: _____

REFERRED BY:

_____ _____

Healthcare Professional Signature & Designation Date

_____ _____ _____

Printed Name of Referring Healthcare Professional Telephone Number Fax Number

Please return completed referral to: Fax: 604-321-6886