



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

Visual Status: (if known) _____

History of seizures: _____

Medications: _____

Medical contraindications for driving: _____

Medical Reports attached: (if available)

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

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