



Referral for Driving Assessment

Please Print

Date: First Name: Family Name: Date of Birth:/...../..... Age: <small style="margin-left: 100px;">D M Y</small> Address: Postal Code: Telephone:	A
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Contact (if other than patient): Relationship: Telephone:	B
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Referred by (please print): Signature: Address: Phone: Fax:	C
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Reason for Referral: Relevant Medical History:	D
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Please fax to:

Kelowna General Hospital
Rehabilitation Centre
2268 Pandosy Street
Kelowna BC V1Y 1T2
Phone: 250-862-4202
Fax: 250-862-4207

Has the patient received a letter from OSMV Yes No (Please include with referral) Are there any other restrictions to drive Yes No Does the patient hold a valid drivers license Yes No DI #	E
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All referral information will be kept strictly confidential and will not be released in any form without signed consent from the client.