



# Referral for Driving Assessment

Please Print

Date: .....		<b>A</b>
First Name:.....	Family Name:.....	
Date of Birth: ...../...../..... <small>D M Y</small>	Age:.....	
Address:.....		
.....	Postal Code:.....	
Telephone: .....		

Contact (if other than patient): .....	<b>B</b>
Relationship:.....	
Telephone:.....	

Referred by (please print):.....	<b>C</b>
Signature:.....	
Address: .....	
Phone:.....	Fax:.....

Reason for Referral:.....	<b>D</b>
.....	
Relevant Medical History:.....	
.....	
.....	

***Please fax to:***

The Wellness Rehabilitation Centre  
Unit 1, 41 River Road E.  
Kitchener, Ontario N2B 2G3

Phone: (519) 749-6787  
Fax: (519) 749-6880

Appointment Time:	<b>E</b>
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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.