



# Referral for Driving Assessment

Please Print

Date: .....		<b>A</b>
First Name:.....	Family Name:.....	
Date of Birth: ...../...../..... D                                  M                                  Y	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:**

Lee Memorial Hospital  
Senior Adult Services  
2776 Cleveland Avenue #807  
Fort Myers FL, 33901

Phone: (239) 334-5634  
Fax: (239) 335-7413

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.