



Referral for Driving Assessment

Please Print

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

Contact (if other than patient):	B
Relationship:.....	
Telephone:.....	

Referred by (please print):.....	C
Signature:.....	
Address:	
Phone:.....	Fax:.....

Reason for Referral:.....	D
.....	
Relevant Medical History:.....	
.....	
.....	

Please fax to:

Lakeridge Health
Regional Evaluation Centre
223 Brock St. N.
Whitby, Ontario L1N 4H6

Phone: (905) 666-8033
Fax: (905) 666-0113

Appointment Time:	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.