Referral Information Form

Driver Assessment Program
Wascana Rehabilitation Centre
2180 – 23rd Avenue
Regina, SK S4S 0A5
Telephone: 306-766-5600
Toll Free: 1-844-766-5600 Fax: 306-766-5144

Client Name: ______________________________ Date of Birth: ______________________

Address: ______________________________ Provincial Health Number: ______________

City/Town: ______________________________ Postal Code: ______________________

Telephone: ______________________________ Driver's Licence #: ______________________

Contact person with whom to arrange appointment (if not the client): ______________________
Is the client aware of the referral? ☐ Yes ☐ No

Reason for Referral: (Include medical diagnoses, history, date of onset, deficits and other relevant information):

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Is there a particular concern that prompted this referral?

☐ Visual Impairment ☐ Physical Impairment

☐ Cognitive Impairment ☐ Amputation

☐ Other: ______________________

Is there a history of known conditions that are episodic and may be incompatible with driving? E.g. seizures, uncontrolled hypoglycemia, hyperglycemia, syncope, hallucinations, delusions, etc . ☐ Yes ☐ No

Physician or Nurse Practitioner Contact Information

____
Physician or NP's Name

____
Address

____
Telephone

____
Fax Number

Referred by:

Name: ______________________________ Signature: ______________________

Agency: ______________________________ Date: ______________________

Telephone: ______________________________ Fax: ______________________

This is a fee for service program so please indicate who will be responsible for payment: ______________________
Please send any relevant information including diagnostic reports, discharge summaries and consult reports.
Please mail to the address listed above or fax to 306-766-5144

For Office Use Only

Date Received: ______________________ Date Information Package Sent: ______________________