cbi HEALTH where better begins

DRIVING ASSESSMENT & REHABILITATION PROGRAM REFERRAL FORM

3300 Bloor Street W, West Tower suite 900 Toronto ON M8X 2X2

t 1.800.558.4599 **f** 1.855.687.0471

Client Name: _____

Address: _____

Postal Code: _____

Date of Birth: _____ Sex: M ☐ F ☐

Contact Person: _____ Phone: _____

Diagnosis: _____

Date of Onset: _____

Has MTO been notified regarding client's medical condition? Yes ☐ **No** ☐

Other Medical Concerns: _____

Seizures: ☐ Yes ☐ No Frequency: _____ Last Episode: _____

Nature of Driving Concerns: _____

Driver's License #: _____

Current Status: ☐ Valid ☐ Suspended ☐ Pending Date of Suspension: _____

MTO file#(if applicable): _____

Have client's up to date medical reports been forwarded to MTO? Yes ☐ No ☐
(IMPORTANT: Medical reports should be faxed to the MTO Fax #: 416.235.3400)

Referral Source: ☐ Medical ☐ MTO ☐ Self ☐ Family ☐ Friend ☐ Insurance ☐ Other

Family Physician (please print/stamp): _____

Phone: _____ Fax: _____

Referring Specialist (please print/stamp): _____

Phone: _____ Fax: _____

Referring Agent Signature: _____ Date: _____

We also conduct assessment for patients that require vehicle modifications and assessment/treatment related to driving anxiety. We are able to complete assessments through any CBI location within Ontario. Please complete and return to the following fax number:

THANK YOU!

drt_ontario@cbi.ca www.cbihealth.ca