# DRIVE-ABLE, LLC

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DRIVER REHABILITATION PRESCRIPTION FORM

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Onset Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has the patient ever had any of the following?

|  |  |
| --- | --- |
| YES NO | YES NO |
| Mental or nervous disorder | Attempted suicide |
| Poor Memory | Drug or narcotic habit |
| Heart Disease | Severe hay fever or asthma |
| Diabetes | Frequent or severe headaches |
| High or low blood pressure | Unconscious for any reason |
| Alcoholism | Fainting spells or blackout |

Do you have any concerns about this patients driving that the driver rehabilitation specialist should be aware of? \_\_\_\_\_\_

Seizure Disorder History (**Complete only if patient has a history)** Age at onset \_\_\_\_ Type of Seizure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequency of seizure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ . This patient has been under my care since \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This patient  **IS**  **IS NOT** reliable in taking prescribed seizure medication

The patient has been seizure free for 6 months or more.  Yes  No

Date you last examined the patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**YOUR SIGNATURE BELOW SIGNIFIES THAT MEDICAL APPROVAL FOR THIS PATIENT TO UNDERGO DRIVER REHABILITATION EVALUATION AND TRAINING IF INDICATED AND SERVES AS A PATIENT PRESCRIPTION**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician Signature Print Name**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Print Address**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Telephone Fax**

**Specialty**