



We Care Mobility

Driver Rehabilitation and  
Community Mobility

## Driving Evaluation Prescription Form

### Patient Information

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

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

Medications: \_\_\_\_\_

Seizures:  yes  no      Precautions: \_\_\_\_\_

Pertinent Medical History: \_\_\_\_\_

\_\_\_\_\_

Reason for Referral: \_\_\_\_\_

This individual is medically stable and able to participate in the following:

Comprehensive driving assessment and training:       Counseling in community mobility as needed.

Physician's Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\* Prescription is valid for six months from the date above

\* Please fax this completed form to 310-359-1479 or email to [purnimakaria@yahoo.com](mailto:purnimakaria@yahoo.com)

\* Schedule your appointment by calling 310-951-1495 or emailing [purnimakaria@yahoo.com](mailto:purnimakaria@yahoo.com)

