



**DRIVING EVALUATION AND TRAINING PROGRAM  
MEDICAL PRESCRIPTION**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Phone(H): \_\_\_\_\_ Phone (other): \_\_\_\_\_

**1. DOES THE PATIENT HAVE ANY OF THE FOLLOWING? (if yes, explain)**

**YES NO**

Medical condition affecting driving ability (i.e. paralysis, visual deficits, etc)

\_\_\_\_\_

**YES NO**

Seizure Disorder / Date of Last Episode:

\_\_\_\_\_

**YES NO**

Taking medications which may affect level of consciousness, memory, etc?  
Please Specify:

\_\_\_\_\_

**2. DO YOU CONSIDER THIS PERSON TO BE A GOOD DRIVING CANDIDATE?**

**YES NO**

\_\_\_\_\_

My signature indicates that I am authorizing this patient to participate in a driver's evaluation and training, as needed.

\_\_\_\_\_  
Physician's Signature (M.D or D.O. only)

\_\_\_\_\_  
Date

**PLEASE FILL THE FOLLOWING OUT COMPLETELY**

PHYSICIAN'S NAME (PRINTED): \_\_\_\_\_

PHYSICIAN'S OFFICE ADDRESS: \_\_\_\_\_

PHYSICIAN'S OFFICE PHONE NUMBER: \_\_\_\_\_

PHYSICIAN'S OFFICE FAX NUMBER: \_\_\_\_\_

PHYSICIAN'S NPI#: \_\_\_\_\_

**PLEASE COMPLETE ALL AREAS OR THE PRESCRIPTION WILL BE RETURNED TO YOU.**

**PLEASE RETURN TO FAX NUMBER (816) 751-7984  
PHONE: (816) 751-7782**