ABILITY KC®

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 consciosness, 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

Revised July, 2017