DRIVING & MOBILITY SERVICES
An Affiliate of KU HealthPartners

Driving Referral Form

Patient Name:

Date of Birth

Home Address

(Cell) Phone

(Home) Phone

E-mail

Reason For Referral

Diagnosis:

Does this patient have a seizure disorder? ◯ Yes ◯ No

If yes, when was the last seizure?

Does the patient have any medical conditions that affects the patient's ability to drive? If yes, please explain.

Does this patient take any medication which may affect consciousness, memory, cognition, vision, hearing, etc?

Is this patient a good candidate for a driving evaluation? ◯ Yes ◯ No

Physician's Name (Printed):

By signing below, I am authorizing this patient to participate in a driving evaluation and driving rehabilitation, as needed.

_ _

Signature

_ _ _ _ _ _ _ _ _ _

Date

Healthcare Provider Phone Number:

Healthcare Provider Fax Number:

Please Fax to KU HealthPartners Driving & Mobility Services at 913-588-6910 or email to Larrs@kumc.edu

KU HealthPartners Driving & Mobility Services Mail Stop 4039 | 3901 Rainbow Blvd. | Kansas City, KS 66160 | Office 913-945-9673