FLX Driver Rehabilitation, LLC

4144 High Banks Road
Geneva, NY 14456
Phone 315-585-9198
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ADAPTIVE DRIVER EDUCATION/TRAINING PROGRAM
REFERRAL FORM

Name:____________________________________

Address:_______________________ City:__________________ State:______ Zip:________

Date of Birth:____________________ Telephone: _____________________

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Purposes for referral: Evaluation _____ Driver Training _____ Equipment _____

Supporting Agency: ________________________________ Phone: ____________________

Disabling Condition:____

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IF LOSS OF CONSCIOUSNESS: individual will require that an MV-80 form be submitted to the Department of Motor Vehicles, Medical Review Unit for approval. If condition is diagnosed as EPILEPSY or one causing a CONVULSIVE DISORDER, a report from a certified neurologist or neurosurgeon must be completed.

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DRIVING STATUS (please answer YES or NO)

1. Does individual have a valid NYS Drivers License? _____
2. Has individual’s current license expired? _____
3. Does individual have a current NSY Drivers permit? _____

ADDITIONAL COMMENTS: ____

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Conflict of Interest Disclaimer: FLX Driver Rehabilitation, LLC is a separate and distinct entity from and is not affiliated with in any manner with URMHC.

Referred by:______________________________ Date:______________________

Address:_________________________________ Phone:______________________

City:________________________ State: _____________ Zip: ______________

PHYSICIAN’S REFERRAL

If this individual is being referred by a physician, please include a physician’s prescription and signature requesting occupational therapy evaluation for driver rehabilitation and diagnosis.

________________________________ ____________________

Physician’s signature Date