TRANSPORTATION SOLUTIONS

Evaluation Request Form

This form must be filled in completely by the requesting physician's office and faxed to: (814) 833-2301 phone, **(814) 833-9230 fax**

Request from the office of: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #:_____Fax: _____

Diagnosis with **ICD-10 CODES**: _____

Date of Last Seizure if applicable: _____

Reason for Referral: ***Occupational Therapy Driving and Community Mobility Evaluation and treatment as indicated.***

Physician's Signature: _____**Date**_____

Patients Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #:_____ Alternate Phone #:_____ Alt. Contact Name:_____

Date of Birth: _____Marital Status: _____ Email Address:_____

Medical Health Insurance Provider: _____

Agreement/Member I.D. Number: _____

FOR OFFICE USE ONLY

Wears (circle all that apply): Contacts ___Glasses ___ Hearing Aid ___

Mobility (circle all that are apply): Cane ___ Walker ____ Wheelchair ____

Are you able to seat self/transfer into car independently? _____ (car or van)

Driver's License #:_____ Is License Valid? _____

Evaluation Location Preference: Erie Corry Dubois Seneca