CAPUCHINO THERAPY GROUP

3601 Marconi Avenue
Sacramento, CA 95821
Phone- (916) 481-1300
Fax- (916) 365-9870

Driver Evaluation Intake

GENERAL INFORMATION

Patient Name: _____ Date of Birth:_____

Address: _____

Phone (Home): _____ (Cell): _____ Gender: Male ____ Female ____

Email:_____

Driver's License / Permit Number: _____ State (on license): _____

Expiration Date: _____ Restrictions:_____

Insurance Company Name:_____ Policy#:_____

Preferred Equipment Vendor:_____

EMERGENCY CONTACT INFORMATION

Contact Name: _____ Relationship: _____

Contact Address:_____

Contact's Phone (Home): _____ Contact's Cell: _____

Email:_____

PHYSICIAN INFORMATION

Physician's Name: _____

Phone:_____ Fax #: _____ Email: _____

Address: _____

OFFICE NOTES

_____

_____

_____

_____

POS Reorder # 1614546

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Driver History Form

DRIVING HISTORY

Number of years of driving experience? _____

Have you driven since your illness/injury? ☐ Yes ☐ No

Has your license been suspended or taken away? ☐ Yes ☐ No

Have you had any accidents or violations in the last five years? ☐ Yes ☐ No

Have you had any DUI convictions? ☐ Yes ☐ No

If answered YES to any of the 4 questions above, please explain here: _____

_____

How often will you be driving? _____

What is the most frequent distance you plan on driving? _____

What is the longest distance you think you might drive? _____

Do you plan to drive on the freeway? ☐ Yes ☐ No

Do you plan on driving at night? ☐ Yes ☐ No

Do you have difficulty with glare? ☐ Yes ☐ No

Have you had issues with contrast sensitivity? ☐ Yes ☐ No

Do you use a GPS? ☐ Yes ☐ No

Have you had difficulty getting in/out of your vehicle since your illness/injury? ☐ Yes ☐ No

If yes, how much assistance did you require? _____

Do you currently own a vehicle? ☐ Yes ☐ No

Make _____ Model _____ Year _____

If you do not own a vehicle, is there a certain vehicle you are hoping to obtain? ☐ Yes ☐ No

Please Describe: _____

If driving from a wheelchair, what kind? _____

MEDICAL HISTORY

Disability/Diagnosis: _____ Date of Onset: _____

Medications: (Please list how often you take each medicine)

_____

Do you wear or use: ☐ Glasses/Contacts (for driving) ☐ Hearing Aid ☐ Splints ☐ Artificial Limbs
☐ Oxygen ☐ Braces ☐ Shoe Lifts ☐ Other

If you use any other type of adaptive devices, please list: _____

Patient Name: _____

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MEDICAL HISTORY CONTINUED

* * * If you have had a recent eye or hearing exam, please acquire a copy of the report prior to your evaluation * *

Do you have any loss of vision? ☐ Yes ☐ No

If yes, please describe the extent and location: _____

Have you ever had seizures? ☐ Yes ☐ No

If yes, when was the last time? _____

Are you currently taking medicine for seizure control? ☐ Yes ☐ No

If so, what medication? _____

If so, when was the last time? _____

Do you have spasms? ☐ Upper Extremity ☐ Lower Extremity ☐ Yes ☐ No

Describe any problems you have using your arms and hands: _____

_____

Describe any problems you have using your legs or feet: _____

_____

Mobility: ☐ Ambulatory ☐ Non-Ambulatory ☐ Short Distances Only ☐ Transfers to Transfer Seat base

☐ Transfers into vehicle ☐ Drive from Wheelchair Adaptive Equipment

(include any additional wheelchair information): _____

How do you get around: ☐ Walk Unassisted ☐ Walker ☐ Cane ☐ Power Scooter

☐ Manual Wheel Chair ☐ Power Wheelchair ☐ Other

This form was completed by: X _____

I have read, and agree to comply with the 'Client Contract' & 'Consent and Release of Information Form'. I understand that my 'Request for Services' form and any other information I send to CTG will be deleted within one month of receipt should I fail to furnish completed paperwork/referral and set an appointment for services in that time frame.

I have read, and agree to the above: X _____

Patient Name: _____

POS Reorder # 1614548

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CLIENT CONTRACT

This Agreement is made this ____ day of _____, by and between Capuchino Therapy Group ("CTG") and _____ ("Client") (collectively, the "Parties").

RECITALS

WHEREAS, CTG provides clinical and behind the wheel driver evaluation as a Certified Driver Rehabilitation Specialist;

WHEREAS, CTG provides adaptive equipment evaluations;

WHEREAS, Client desires to undergo training and evaluation with CTG.

NOW THEREFORE, in consideration of the mutual covenants and conditions set forth herein, the Parties agree as follows:

1. Equipment. CTG shall provide an appropriate automatic transmission automobile, approved by the Department of Motor Vehicles ("DMV"), equipped with hand controls, steering devices, a left foot accelerator, and/or other equipment as/if needed to provide the agreed upon services.
2. Payment. Client shall pay for said services by cash or credit card or by a third party funding source which has pre-authorized said services. If insurance or another funding source is not guaranteed, then payment in full is expected at the time of the evaluation/service.
3. Refunds. Due to the nature of our work, our services are non-refundable once initiated. All prepaid package training sessions are valid for 3 months from date of purchase and non refundable.
4. Dates and Times for Instruction. Client agrees to appear for the services at the pre-set dates and times; however, in the event of unforeseen contingencies, Client, or CTG, may make changes to the schedule as needed. Changes must be made as far in advance as possible and all parties notified by telephone, or in person, in each case.
5. Failure to Appear. Should the Client fail to be at the place of appointment, a cancellation fee of 50% of the expected rate per incident will be charged. Being moderately late for an appointment may not constitute a cancellation, but that time will be billed as part of the session.
6. Termination. Client realizes that either his/her physician or the therapist may in their professional judgment, decide to terminate participation in the Driving Program at any time to ensure Client's safety and the safety of others.
7. No Guarantee. CTG does not guarantee that Client will successfully pass the DMV License Examination upon completion of the course of instruction; however CTG will exert every effort in preparing Client to meet and exceed the requirements of the examination when applicable.
8. Insurance. Client verifies that they are currently insured under California law and that they understand and agree that their auto insurance will be utilized as the primary insurance in the unlikely event of an incident while they are operating CTG vehicle or their personal vehicle during an evaluation or treatment session. Client agrees to maintain liability insurance as required under California law.
9. Entire Agreement. This Contract constitutes the entire agreement between the Client and CTG. Verbal assurances or promises not contained herein are not binding in any way on the Client or CTG. This Agreement may only be modified by a writing signed by both Parties.
10. Release of Information. Client consents to the release of certain medical information and/or evaluations to his/her physician, the DMV and those involved in my care as set forth in Exhibit A hereto.
11. Waiver and Release. Client understands and acknowledges that there is a risk of accident and/or injury while participating in the instruction and/or services provided by CTG. Fully aware of those risks, Client hereby waives and releases CTG of any and all claims, demands, complaints, cross-complaints or actions which arise out of any injury or loss suffered by Client while participating in any instruction or service provided by CTG under this Agreement.

IN WITNESS WHEREOF, the Parties have executed this Agreement effective the date set forth above.

_____ _____

Client Signature / Date Capuchino Therapy Grp. Rep / Date

_____

Parent/Guardian Signature (if applicable) / Date

Patient Name: _____

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EXHIBIT A
DRIVER EVALUATION AND TRAINING
CONSENT AND RELEASE OF INFORMATION FORM

I, _____ understand that I am taking a comprehensive driving evaluation and training with a Certified Driver Rehabilitation Specialist (CDRS) for the purpose of determining my ability to drive a motor vehicle. The evaluation will consist of a clinical assessment, vehicle and equipment assessment and behind the wheel assessment. I consent and agree to participate in all of the evaluation procedures constituting the program. I agree to abide by the results obtained. These recommendations may include vehicle and adaptive equipment requirement, re-evaluation, or requests for further medical treatment or consultations. I am solely responsible for completing these recommendations, and understand that documentation of my ability to drive a motor vehicle will be contingent on my completion of all recommendations given by a Certified Driver Rehabilitation Specialist.

I understand that driving a motor vehicle on public roads is a privilege granted me by the DMV. I understand that safely driving a motor vehicle requires good physical control of the vehicle, as well as good visual, perceptual, and cognitive skills by the driver in order to react to the changing traffic environment. I understand that my medical diagnosis may impair my driving ability. I am voluntarily submitting to a driver assessment in order to ascertain if I may have any physical, mental, visual, cognitive and/or perceptual impairment that may impede my ability to drive a motor vehicle safely.

I authorize the Certified Driver Rehabilitation Specialist to release all information of my driver evaluation and training program to the consulting physician and those involved in my care. Should I fail the battery of physical, cognitive, visual-perceptual tests, and/or behind the wheel assessment, I understand that the physician or CDRS may be required to notify the local DMV Medical Branch (DMV Safety Office) as mandated by state law. I give this consent with awareness that such disclosure may result in the revocation of my license to drive or prevent me from obtaining such a license in the future. I am aware that the DMV Medical Branch/Safety Office has the authority to make final decisions regarding my driving status. If I pass the drivers evaluation, I understand that I still must consult with my physician regarding my test results prior to operating a motor vehicle independently or undergoing additional driver training.

I further consent to and authorize that my medical information relating to my diagnosis, prognosis, or treatment may be released to the Certified Driver Rehabilitation Specialist. I understand that the purpose or need for this disclosure is to determine my safety to drive and all this information will be held in strict confidence between me and the CDRS. I further agree and do hereby release the Certified Driver Rehabilitation Specialist and my physicians from any claims of any nature arising out of my participation in the driver assessment and training service. Each evaluation and training session will be a billable expense. I understand that I am responsible for all or part of the bill if my other funding sources refuse payment. I understand that I am responsible for full payment at the time services are rendered.

_____/_____ _____/_____
Signature of Client/Date Certified Driver Rehabilitation Specialist/Date
(Understanding the above information)

_____/_____
Signature of Parent/Guardian/Date
Relative of Other (Witnessed the explanation of this contract; signature optional)

Patient Name: _____

POS Reorder # 1614550

CAPUCHINO THERAPY GROUP

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Physician Referral

Driver Rehabilitation/Adaptive Driver Evaluation & Training

(Fax to 916-365-9870)

Date: _____

Patient's Name: _____ **DOB:** _____

Diagnosis: _____

Diagnosis ICD-10 Code(s): _____ **Date of Onset/Injury:** _____

Please also include any medical chart notes relating to the patient's above diagnosis.

Patient cleared for evaluation if medical event was less than 6 months ago? ☐ **Yes** ☐ **No** ☐ **N/A**

Precautions: _____

History of seizures: ☐ **Yes** ☐ **No** **Date of last seizure:** _____

Referral for:

- ☒ **OT/PT Adaptive Driving/Driver Rehabilitation Evaluation & Training**
- ☒ **Adaptive Equipment Assessment & Order (As Needed)**
- ☒ **Dependent Passenger Evaluation (As Needed)**
- ☐ **Other:** _____

Physician's Name (Please Print): _____ **NPI:** _____

Signature: _____ **Date:** _____

Physician's Phone: _____ **Physician's Fax:** _____

Physician's Address: _____

City: _____ **State:** _____ **Zip code:** _____

Physician's E-Mail Address: _____ **@** _____

MD would like to receive reports via ☐ **E-Mail or** ☐ **Fax**
(Please check one)