CAPUCHINO THERAPY GROUP

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Sacramento, CA 95821
Phone: (916) 481-1300
Fax: (916) 365-9870

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)

Patient Name:____________________________________