University of Kentucky Driver Rehabilitation Evaluation and Training Program Physician's Consent Form

Name			**DOB**	
Home #		**Mobile #**		
Address				
Occupation				

This Form Is to Be Completed by The Referring Physician Only

1. **If hospitalized in the past two years, detail cause, date(s) and discharge diagnosis:**

2. **Referring Diagnosis:**

3. **Has the patient ever had (if yes, explain in comments)**

	YES	**NO**
Substance Abuse Disorder	☐	☐
Cerebrovascular Disorder	☐	☐
Musculoskeletal Disorder	☐	☐
Peripheral Vascular Disorder	☐	☐
Respiratory Disorder	☐	☐
Cardiovascular Disorder	☐	☐
Diabetes or other Endocrine Disorder	☐	☐
Psychosocial, Emotional, or Mental Disorder	☐	☐
Visual or Hearing Impairment	☐	☐
Other (list)	☐	☐

4. **Medications**:

5. **Has the patient ever had a seizure? Yes☐ No ☐**
    - If "Yes" date of last seizure. Click or tap to enter a date.

Human Development Institute - University of Kentucky
Return form to: Driverrehab@uky.edu; (fax) 859 323-0071; (phone) 859 218-7979

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Based on my professional opinion, this person is in an appropriate medical status to participate in a driver rehabilitation program.   Yes ☐   No ☐

Comments:

Physician Name			
Address			
Telephone		FAX	

Physician Signature: ______________________________ Date: ________________

***This individual has requested to participate in a driver evaluation, driver training and/or vehicle modification program. The evaluation will be conducted by a Certified Driver Rehabilitation Specialist (CDRS). The Physician's Consent is <u>NOT</u> the final determining factor for obtaining a driver's license. The final decision will be made on the recommendation of the Certified Driver Rehabilitation Specialist (CDRS) and the Division of Driver Licensing.**

Revised 1/24

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