2825 Pecan Blvd.
McAllen TX 78501
956-616-5566
Rstdrivingschool@hotmail.com

Driver Rehabilitation Program Referral

Healthcare Provider: To assist us in performing a driving assessment, please complete the following information:

Date: ____

Client Name: ___________________________________Date of Birth: __________________

Address: ____________________City: _______________State: ___________Zipcode: _________

Primary Contact # _________________________ Secondary Contact #________________________

Driver's License Number: _____________________

Diagnosis: ____

____

Seizure History: Yes___ No ___ If Yes, has this person been seizure free for at least 1 year? Yes__ No___

Any History of loss of consciousness, blackout, vertigo, dizziness, altered vision or related symptoms?

Yes ____ No ____ If Yes, Please Specify: ____

Is this person currently taking any medications that can potentially interfere with the ability to drive?

Yes ____ No ____ If Yes, Please Specify: ____

Prescription for Driving Evaluation

Healthcare Providers Name: ____

License Number: ____

Address: ____________________City: _______________State: ___________Zipcode: _________

Phone Number: ____________________________ FAX Number: ____________________________

Signature: ____

Please return this form to RST Mobility Services