

Name: _____
Date of Birth: _____
Referring Physician: _____

DRIVER PRE-ASSESSMENT FORM

Driving Program Coordinator: Outpatient Department
(207) 662-8377
Fax #: (207) 662-8423

1. Have you received written materials about the Driving Program? **Yes** _____ **No** _____

2. Do you understand that this is a private pay program? **Yes** _____ **No** _____

3. Have you ever had seizures or periods of blackout? **Yes** _____ **No** _____
If yes, please indicate the last occurrence. _____

4. Do you currently have a valid driver license or permit? **Yes** _____ **No** _____
If yes, please provide the information below:
License/permit number: _____
State from which license was issued: _____
Expiration date: _____
Restrictions: _____

If you don't have a license/permit, please explain:

5. Have you ever had your driver license suspended or revoked for any reason? **Yes** _____ **No** _____
If yes, please explain in the space provided below.

6. Have you had your vision checked? **Yes** _____ **No** _____
Bring information from vision check to the appointment if available.

Do you wear glasses/contacts? **Yes** _____ **No** _____ If yes, please bring glasses/contacts to evaluation.

7. List of current medications: _____

8. Who is recommending that you have a driving evaluation?
Physician order _____ Family concerns _____ Other _____
Name of Physician: _____

9. Please list any questions or concerns you have about our program.

NOTE: You must attach a copy of your driver license or learner permit to be considered for our driver assessment and education services.

Pre-assessment form