Community Independence Solutions, PLLC. **Special Needs Driving School l Driver Rehabilitation l Occupational Therapy**
2391 NE Interstate 410 Loop Ste 104, San Antonio, TX 78217 l P 210.346.8311 l F 210.634.2652 l referrals@cisofsa.com l www.cisofsa.com/referring

PHYSICIAN REFERRAL FORM

Referrals should include patient's (1) demographics, (2) most recent office note, and (3) current list of medications. All referrals can be faxed to **210.634.2652**, emailed to **referrals@cisofsa.com** or uploaded through our website at **https://www.cisofsa.com/referring**

PATIENT INFORMATION

REFERRAL DATE	PATIENT NAME		DOB
ADDRESS			PHONE
CITY	COUNTY	STATE	ZIP
EMAIL	MALE / FEMALE	HEIGHT	WEIGHT
PRIMARY CONTACT NAME	RELATIONSHIP		PHONE
DRIVERS LICENSE / PERMIT #	STATE		EXP DATE

MEDICAL HISTORY

DIAGNOSES

DATE OF ONSET	DX CODE(S)
MOBILITY STATUS	

(CHECK ALL THAT APPLY)

☐ AMBULATORY ☐ CANE ☐ WALKER / ROLLATOR ☐ WHEELCHAIR: ☐ POWER ☐ MANUAL

TRANSFER STATUS

ADDITIONAL NOTES

PHYSICIAN CONSENT

(CHECK ALL THAT APPLY)

☐ COMPREHENSIVE DRIVING EVALUATION/TRAINING
I consent to my patient participating in a program to evaluate motor vehicle operation capacity

☐ RETURN TO DRIVE/SENIOR SAFETY DRIVING EVALUATION/TRAINING
I consent to my patient undergoing a evaluation to determine driving fitness and participate in training if recommended following a major health event or change in medical status

☐ *Please check if you would like to receive a copy of reports faxed to you*

PHYSICIAN SIGNATURE	DATE
PHYSICIAN NAME (PRINT)	PHONE
ADDRESS	FAX

PLEASE NOTE: *Signature/Date stamps are not acceptable. By signing this order you are acknowledging that you are an attending physician of this patient. Order expires 6 months from date signed.*