DriveABLE REFERRAL FORM

Oregon Driver Education Center Inc.

☐ **DCAT** (In-Office Assessment)
☐ **DORE** (On-Road Evaluation)

Please Print

DriveABLE™ Driven by Research
Assessing the Medically At-Risk Driver

A

Client Consent for referral and release of assessment results.
I agree that my name and relevant information can be sent to the DriveABLE™ Assessment Centers.

Signature: _____

I agree that a copy of all my DriveABLE™ assessments can be sent to this center to facilitate my ongoing treatment.

Signature: _____

B

Client information

Date: _____

First Name:_____ Last Name:_____

Date of Birth:_____/_____/_____ Age:_____ Telephone:_____

Address:_____ City:_____ Zip Code: _____

D

Referred by (please print):_____

Address: _____

Organization: ☐ Judicial ☐ DMV ☐ Hospital/Clinic ☐ PT/OT ☐ Workers Comp. ☐ Self/Family
Organization Name:_____

Phone:_____ Fax:_____

E

Reason for Referral:_____

Physical problems that may impact driving:_____

Hearing or Vision problems:_____

Office Use Only

☐ **Visa**
☐ **Master Card**
☐ **Discover Card**

Acct #:_____Exp_____

Cardholder Name: _____

F

Appointment Time and Date:
_____

Valid Driver License #: _____

Exp:_____

All referral information will be kept strictly confidential and will not be released in any form without signed consent from the client.

Attention: William T. Mary
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Salem, OR 97302
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