Vancouver CoastalHealth
Promoting wellness. Ensuring care.

DRIVER REHABILITATION REFERRAL

GF Strong Rehab Centre
4255 Laurel St.
Vancouver, BC V5Z 2G9
Tel: 604-737-6207

Incomplete referrals will not be processed.

Patient Surname: _____ Patient First Name: _____

Date of Birth: (month, day, year) _____ PHN: _____

Address: _____

Telephone: _____ Other contact: _____

Language: ☐ English ☐ Other_____ Family Physician: _____

Contact: (if other than patient) _____

Relationship: _____ Telephone: _____

Diagnoses/Medical Conditions (include relevant dates and functional status):

_____

_____

_____

History of seizures: _____

History of sleep apnea: _____

Mobility Status: ☐ Ambulatory ☐ Manual Wheelchair ☐ Power Wheelchair ☐ Scooter ☐ Other:_____

Medications: _____

_____

Precautions: (ARO's, Restrictions, Aggression Risk): _____

_____

☐ **Consults attached:** (e.g. ophthalmology, occupational therapy, physiatry, RoadSafetyBC letters, etc.)

Has a Driver's Medical Exam been requested by RoadSafetyBC? ☐ Yes ☐ No

Has RoadSafetyBC been notified of this driver ☐ Yes (date) _____ ☐ No

Has RoadSafetyBC requested an assessment? ☐ Yes (please include letter) ☐ No

Funding Source: ☐ **WSBC** ☐ **ICBC** ☐ **Self** ☐ **Other**_____.

Referred by:

_____ _____

Healthcare Professional Signature & Designation Date

_____ _____ _____

Name of Referring Healthcare Professional Telephone Number Fax Number

Please return completed referral to: **GF Strong Referral Fax: 604- 730- 7904**