



# Shepherd Center

2020 Peachtree Road, NW  
Atlanta, GA 30309-1465  
404-352-2020 shepherd.org

## *New Patient Form* *Assistive Technology*

Seating  Driving

\_\_\_\_\_  
Last First Middle

\_\_\_\_\_  
Address City State Zip County

\_\_\_\_\_  
Phone # F  M  Sex Marital Status DOB

\_\_\_\_\_  
SS# Employer Name

\_\_\_\_\_  
Next of Kin Relationship Phone #

\_\_\_\_\_  
Referring Physician Address Phone #

\_\_\_\_\_  
Diagnosis 1 Diagnosis 2

\_\_\_\_\_  
Onset Date Cause of Injury Date

\_\_\_\_\_  
Insurance ID # (Primary) Phone #

\_\_\_\_\_  
Address Group Policy

\_\_\_\_\_  
Insurance ID # (Secondary) Phone #

\_\_\_\_\_  
Address Group Policy

\_\_\_\_\_  
Policy Holder DOB SS#

\_\_\_\_\_  
Case Manager Phone #

**Please fax to: Assistive Technology Center Driving Program Fax: 404-350-7356**

If mailing this form, please send to: Shepherd Center Driving Program  
2020 Peachtree Road NW, Atlanta, GA 30309 / Phone: 404-350-7760



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## *Driver Rehabilitation Referral*

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Work Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Referral Source \_\_\_\_\_

Driver's License: Yes  No  If yes, license # \_\_\_\_\_ Exp. Date \_\_\_\_\_

Learner's Permit: Yes  No  If yes, permit # \_\_\_\_\_ Exp. Date \_\_\_\_\_

Current Diagnosis: \_\_\_\_\_ Onset Date: \_\_\_\_\_

### **MEDICAL HISTORY**

Arthrogryposis \_\_\_\_\_

Amputee LLE  RLE  LUE  RUE

Cerebral Palsy \_\_\_\_\_

Cerebral Vascular Accident: R  L

Learning Disability \_\_\_\_\_

Neuromuscular Disease \_\_\_\_\_

Orthopedic Problems \_\_\_\_\_

Peripheral Vascular Disease \_\_\_\_\_

Progressive Neurological Disease \_\_\_\_\_

Psychiatric/ Psychological Diagnosis \_\_\_\_\_

Spinal Cord Injury: Level \_\_\_\_\_

Incomplete  Complete

Spina Bifida \_\_\_\_\_

Traumatic Brain Injury \_\_\_\_\_

Tumor (Location) \_\_\_\_\_

Vision Problems \_\_\_\_\_

Other \_\_\_\_\_

Has the patient had a seizure or episode within the last year? No  Yes  Date \_\_\_\_\_

Current medications that may affect safe driving: \_\_\_\_\_

Do you recommend any driving restrictions? Please specify: \_\_\_\_\_

Physician signature \_\_\_\_\_ Date \_\_\_\_\_

Name (print or type) \_\_\_\_\_ M. D. or D. O. UPN#/LIC# \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Fax ( \_\_\_\_\_ ) \_\_\_\_\_

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MR # \_\_\_\_\_

## *Vision Exam and Approval for Driving Evaluation*

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Work Phone ( \_\_\_\_\_ ) \_\_\_\_\_

In regard to the request to resume safe independent driving, this form must be completed by your ophthalmologist, optometrist or low vision specialist specifically addressing the following visual areas related to driving.

Shepherd Center is unable to perform the pre-screen or on-the-road evaluation without first obtaining this signed form if a visual concern is present due to disability.

Date of Exam: \_\_\_\_\_  Corrective lens: near  distance  both

Diagnosis: \_\_\_\_\_  Telescopic lens: type \_\_\_\_\_ power \_\_\_\_\_

	Right	Left	Both	Comments
Corrected visual acuity				
Horizontal visual fields in degrees				<input type="checkbox"/> Goldman <input type="checkbox"/> Humphrey <input type="checkbox"/> Confrontation
Peripheral vision				
Saccades				
Range of motion				

Color Vision: Intact  Impaired  Comments \_\_\_\_\_

Night Vision: Intact  Impaired  Comments \_\_\_\_\_

Depth Perception: Intact  Impaired  Comments \_\_\_\_\_

Diplopia: Absent  Present  Comments \_\_\_\_\_

Do you recommend any driving restrictions? Please specify: \_\_\_\_\_

I understand by signing this form the above named person has met state requirements for vision in regard to driving and is visually appropriate to pursue a driving evaluation.

Physician signature \_\_\_\_\_ Date \_\_\_\_\_

Name (print or type) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Fax ( \_\_\_\_\_ ) \_\_\_\_\_

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