



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 (_____) _____ Work Phone (_____) _____

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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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