Easterseals
Driver Assessment Program
158 State St. Meriden, CT 06450
Phone: (203) 630-2208 / Fax: (203) 634-0341
Email: driver@eswct.com **www. Easterseals.com/waterburyct**

OUTPATIENT DRIVER ASSESSMENT REFERRAL

In order to comply with our billing criteria and documentation procedures we ask that the referring physician sign this prescription and provide a diagnosis along with ICD-10 codes, medication list and last office note/medical history.

Please fax the following to Easter Seals Mobility Center

1. **Completed and Signed Prescription**
2. **Include diagnosis code on script**
3. **Medication List**
4. **Last Office Note / Medical History**

Patient Information: Date: _____

Name: _____ DOB: _____

Address: _____

Home Phone: _____Cell/Work Phone: _____

Emergency Contact: _____ Phone _____

Diagnosis: _____ ICD-10 Codes: _____

Prescription For:

Occupational Therapy Evaluation & Treatment, Driving Assessment

Physician's Information:

Physician's Name (**Print**): _____

Physician's Signature: _____ Date: _____

Physician's Address: _____

NPI # _____ Frequency: 1 X

Phone: _____ Fax: _____ 5/16