DriveABLE Cognitive Assessment (DCAT) Referral Form

Patient Information

First Name

First Name

Last Name

Last Name

Date of birth

Address

Phone

Email

Contact (if other than patient)

First Name

First Name

Last Name

Last Name

Relationship

Phone

Email

Referring Physician / Hospital / Other Medical Professional

Name

Address

Phone

Fax

Does client wear a hearing aid

- Yes
- No

Does client wear corrective lenses

- Yes
- No

Does client have limited upper extremity mobility or hand/finger dexterity

- Yes
- No

Is English a second language

- Yes
- No

If yes, what is their primary language

If yes, what is their comprehension level

- None
- Moderate
- Good

Is adaptive equipment required to drive

- Yes
- No

Does client have valid driver's license

- Yes
- No

Comments/questions