Compass Driving Rehabilitation, PLLC

2522 N. Proctor St., PMB 360 • Tacoma, WA 98406
P: 253-324-8022 • F: 253-295-3800

Referral Form: Occupational Therapy Driving Rehabilitation

Patient Information

Name: _____ **DOB:** _____
Phone: _____

Referring Provider

Name / Credentials: _____ **Clinic:** _____
Phone: _____ **Fax:** _____

Reason for Referral (check all that apply)

☐ Medical condition impacting driving
☐ Neurological condition
☐ Post-injury / post-surgical return to driving
☐ Patient / family concern
☐ Cognitive, visual, or perceptual concerns
☐ Age-related functional changes
☐ Adaptive equipment needs
☐ WA State DOL request

Primary Diagnosis / Relevant History:

Requested Service

☐ Comprehensive Driving Evaluation (clinical + behind the wheel on-road)

Additional Clinical Information

Provider Authorization

I am referring this patient for an **occupational therapy driving rehabilitation evaluation and/or intervention** as clinically indicated.

Provider Signature: _____ **Date:** _____

Notes:
• Services provided by an Occupational Therapist, Driver Rehabilitation Profession (DRP)
• Private pay; insurance not billed
• Written recommendations will be shared with the referring provider and WA State DOL if deemed necessary

Please fax form to: 253-295-3800 (HIPPA compliant fax)