Driver Assessment Program

158 State St. Meriden, CT 06450
Phone: (203) 630-2208 / Fax: (203) 634-0341
Email: driver@eswct.com

OUTPATIENT DRIVER ASSESSMENT REFERRAL

In order to comply with our billing criteria/documentation procedures we ask that the referring provider 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 Easterseals Driver Assessment Program

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**:** _____

Contact for Scheduling other than the Patient: _____

Phone _____ Cell phone _____

Emergency Contact: _____

Phone _____

Prescription For:

Comprehensive Driver Assessment

Diagnosis: _____ ICD-10 Codes: _____

Physician's Information:

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

Physician's Signature: _____ Date: _____

Physician's Address: _____

NPI # _____

Phone: _____ Fax: _____