DRIVEABLE COGNITIVE ASSESSMENT REFERRAL

Assessment location: Autonomy Community Therapy
ACT Inc.

Address: 6900 Boulevard Décarie, Bureau M170
CSL (Québec) H3X 2T8

Autonomie Communautaire Thérapie | Autonomy Community Therapy

Date: ____________________

Family Name: ___________________________ First Name: _______________________

Date of Birth: _____/_____/_______
D M Y

Address: ____

Phone: ______________________ Email: ____

Contact (if other than patient): ____

Relationship: ____

Phone: _______________________ Email: _________________________________

Referred by (please print): ____

Address: ____

Phone: __________________________ Fax: ________________________________

Signature: _________________________________

Please circle appropriate:

Does client wear hearing aid?	Y / N
Does client wear corrective lenses?	Y / N
Does client have limited upper extremity mobility or hand/finger dexterity issues?	Y / N
Is English a second language?	Y / N
If yes, comprehension level: None Moderate Good	
Is adaptive equipment required to drive?	Y / N
Does client have valid drivers license?	Y / N

Other relevant medical considerations, please explain:

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Please fax completed referral form to: 514-733-5005 or call 514-733-1414 for questions.

DRIVEABLE

All referral information will be kept strictly confidential and will not be released in any form without signed consent from the client.