INOVA Loudoun Hospital
Outpatient Specialty Rehabilitation – Driver Rehabilitation
44035 Riverside Parkway, Suite 500C
Leesburg, VA 20176
Phone: 703-858-6390
Fax: 703-858-8208

Form A – Service Agreement

Client Contract

1. This contract is between INOVA Loudoun Hospital's Outpatient Specialty Rehabilitation department, hereafter referred to as the school and

Name:_____

Address:_____

State:_____ Zip Code:_____

Hereafter referred to as the client, covers Driver Evaluation/Education that encompasses:

A. Clinical Evaluation
B. Behind the Wheel Evaluation
C. In-car instruction/training
D. The use of adaptive equipment to facilitate independence in driving.
E. Other:_____

This contract will remain in effect for the duration of treatment/driver rehabilitation services.

2. Equipment – Brant's Driving School shall provide a vehicle, approved by the Virginia Division of Motor Vehicles, equipped with adaptive equipment specific to the needs of the client as necessary.
3. Insurance – Brant's Driving School will provide insurance coverage for their vehicle and the patient while in the vehicle.
4. Payment for the above services may be made by cash, check, or credit card at the time of service delivery. If an outside funding source (i.e. workers comp or vocational rehab) is to be used, it must be pre-authorized prior to time of service. At this time insurance is not deemed an allowable payment source.
5. Dates and times for instruction will be strictly adhered to; however, in the event of unforeseen contingencies, the client, or the school, may make changes to the schedule as needed. Such changes must be made as far in advance as possible and all parties notified by telephone, or in person, in each case.
6. Should the client fail to attend their appointment without notifying the school, a cancellation fee of $50 will be charged to the client, to be collected prior to the next point of service.
7. I realize that either my physician or the therapist may in their professional judgment, decide to terminate my participation in the driving program at any time to ensure my safety and the safety of others.
8. I realize that either my physician or therapist may notify the DMV Medical Group if it is recommended that the client retire from driving for their own safety or the safety of others.

_____ _____
Client Signature Date Learner's Permit or License #

_____ _____
Parent's Signature (when applicable) Date DRS Representative Date

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Form B – Medical Approval for Driving Evaluation

This form must be completed and signed by a physician before scheduling an appointment.

Patient Name: _____

Diagnosis: _____ Date of onset: _____

Name of Medicine:	Dose:	How Often:	For What Problem:	Potential Side effects:

Has the patient ever had any of the following:

A. Mental or nervous disorder	Yes	No	G. Alcoholism	Yes	No
B. Poor memory	Yes	No	H. Drug Abuse	Yes	No
C. Heart Disease	Yes	No	I. Motion Sickness	Yes	No
D. Diabetes	Yes	No	J. Severe Headaches	Yes	No
E. High/Low Blood Pressure	Yes	No	K. Seizures	Yes	No
F. Dizziness	Yes	No	L. Fainting Spells	Yes	No

Do you have any medical concerns regarding this client driving that the driver rehabilitation therapist should know?_____

_____

Seizure Disorder History: **To be completed only if patient has had a seizure.**

Date of last seizure: _____ Type of seizures: _____ Frequency of seizures: _____
I understand that Virginia state law requires that a patient is seizure free for at least 6 months prior to starting/re-starting to drive.

By signing below I understand that I am providing medical approval for this patient's driving evaluation. I understand I will be given a copy of the detailed report upon completion.

_____ Date: _____ Fax number: _____
Doctor's Signature to receive report.

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Form C – Patient Information

Name: _____ Date of Birth: _____ Age: _____

Address: _____

Phone: Home ( ) _____ Cell ( ) _____ Date of last eye exam: _____
Do you wear: ___Glasses ____Contacts ____Prism Glasses ____Eye Patch
Are you receiving therapy now? ___OT ___PT ___ST Where? _____

Diagnosis & Medical Conditions:_____

_____

_____

History of seizures? _____Date of Last Seizure:_____

Describe any surgeries or hospitalizations in the last 10 years: _____

_____

Driver's License or Learners Permit No: _____ Previous driving experience?_____

Have you had any accidents, license revocation, suspension or tickets within 5 years? _____

If yes, give brief details:
_____

_____

Do you currently own a vehicle? (Circle those that apply) Yes No, Standard/Automatic
2 door/4 door/Van/SUV/Truck Model_____ Year _____

Does the vehicle have adaptive driving equipment or modifications?
Describe_____

Installed by: _____ Date Installed: _____

Current Living Situation:

_____

Current School/Work Situation:

_____

Describe your physical disability, if any

_____

What adaptive equipment do you use for mobility, self-care or functional independence?

_____

_____

Please rate the functional level in each category with following rating: I = independent, D – Dependent A – Assistance needed

_____Dressing	_____Bathing	_____Feeding	_____Cooking
_____Telephone	_____Bed Transfer	_____Toilet transfer	_____Car transfer

I understand that an appointment for my driving evaluation will only be scheduled once all forms (Service Agreement, Medical Approval, and Patient information) are signed by the appropriate parties and returned. I understand that someone capable of driving is to accompany me to the evaluation.

_____ Date: _____

Patient Signature

To protect yourself, we encourage you NOT TO DRIVE BEFORE YOUR APPOINTMENT!