Regina Qu'Appelle
HEALTH REGION

Referral Information

Driver Assessment Program
Wascana Rehabilitation Centre
2180 - 23rd Avenue
Regina, Sask. S4S 0A5
Phone: 766-5600

Client Name: _____ Date of Birth: _____

Address: _____

City/Town: _____ Postal Code: _____

Phone: _____

Contact person with whom to arrange appointment (if not client): _____

Is client aware of referral? ☐ Yes ☐ No

Reason for Referral: (include medical diagnoses, history, date of onset, deficits, and other relevant information:

_____

_____

_____

_____

Is there a particular concern that promoted this referral?

☐ Visual Impairment ☐ Motor Impairment

☐ Cognitive Impairment

☐ Other: _____

History of Seizures: ☐ Yes ☐ No

Date of last seizure: _____

Physician Contact Information

_____
Physician's Name

_____
Address

_____
Telephone

_____
Fax Number

_____
Date

Referral Initiated by:

Name: _____ Signature: _____

Agency: _____

Phone: _____

This is a fee for service program.
Please indicate who will be responsible for payment of fee: _____
Please send relevant information, including diagnostic reports, discharge summaries and neuropsychological reports.
Please mail to the above address or fax to (306) 766-5144

FOR OFFICE USE ONLY

Date Received: _____ Date Information Package Sent: _____