KINETIK DRIVER EVALUATION PROGRAM
8TH FLOOR, SASKATOON CITY HOSPITAL
701 QUEEN STREET,SASKATOON, SK, CANADA S7K OM7
TEL (306)655-8612 FAX (306)655-7878

Referral Date: _____

Client name: _____

Address: _____

_____

_____

Phone: _____

**Please include postal code

DOB/Age: _____

PHN: _____

Sex: M /F

Currently Driving: Yes No

PIC # _____
Valid / Invalid /Suspended / Don't know

Alternate contact person (if applicable):
Name: _____

Relation to client _____

Phone: _____

Family Physician:_____
Location: _____
Fax number: _____

Other Physicians or Health Care Professionals involved with client:

_____
_____
_____
_____
_____
_____

Assessment Date: _____

Referral Source: Physician Specialist OT
ABI SGI WCB HTB GAU KCC Rehab
School Other: _____

☐ **Confidential** ☐ **Non-confidential**

Contact Person: _____
Contact number:_____

Reason for Referral: _____
SCI ABI Neurological Orthopedic Vision
Cognitive Other _____

Diagnosis: _____

Client has been seen at: SCH RUH SPH Other _____

Payer: Self pay SGI – injuries dept WCB ABI
Other _____
Insurance Rep: _____
Insurance Claim # _____

Previous DEP assessment Yes/No
Date: _____

Comments:

_____
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For Office use only