



2381 Lawrenceville Road
 Lawrenceville, NJ 08648-2024
 609-896-9500 voice
 609-8950242 fax
 www.slrc.org web

Driving Program Intake Form

Patient Name _____ SS# _____
 Address _____ SLRC ID# _____
 _____ DOB _____ Age _____ Sex: M F
 Employer _____ Marital Status M D Sep Single W
 Home Phone _____ Work or Cel Phone _____
 Does patient currently have a valid drivers license? Yes No
 Drivers License Number _____ State _____ Exp. Date _____

Comments: (i.e. DMV notification?) _____

Family Information / Nearest Relative

Name _____ Relationship _____
 Address _____
 Phone # Home _____ Work _____ Cell _____

Referring Physician

Name _____
 Phone No. _____ Fax No. _____ Prescription Y Patient will bring

Diagnosis / Reason for Referral _____

Date of Onset / Accident _____ MVA Related? Y N Work Related? Y N

Significant Medical History

<input type="checkbox"/> Stroke	<input type="checkbox"/> HTN	<input type="checkbox"/> Asthma	<input type="checkbox"/> Vision Problems
<input type="checkbox"/> Head Injury	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Respiratory	<input type="checkbox"/> Hearing Problems
<input type="checkbox"/> Neurological Disorder	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Currently Pregnant

Other _____

Are you allergic to latex? Y N

Are you allergic to any medications? If so, please list: _____

Payment Information

Self Pay Department of Vocational Rehabilitation Insurance

Insurance Information _____

Primary Insurance _____ Secondary Insurance _____

Subscriber Name _____ Subscriber Name _____

Address _____ Address _____

Phone _____ Phone _____

Information Verified By: _____ Confirmation Letter Sent? Y N Date _____ Computer? Y N