Alberta Health Services

Affix patient label within this box

Driver Evaluation and Training Service (DETS) Referral

Please complete all sections of this form, print, sign, and return by fax to **Occupational Therapy Services** at **780.735.7946**.
For further assistance call 780.735.7938. For general program information call 780.735.8825.

Before completing this referral ensure that

- Alberta Transportation, Driver Fitness and Monitoring is aware that your client has a medical condition that may impact ability to drive safely via submission of a Medical Evaluation for Motor Vehicle Operators or detailed letter outlining concerns and intentions
- Alberta Transportation, Driver Fitness and Monitoring is aware that you are referring your client to DETS for evaluation. Please fax a copy of the referral form to 780.422.6612.

Incomplete referrals will be sent back to referring source.

Client's Name *(last, first)*		Date of Birth *(yyyy-Mon-dd)*
Address	Postal Code	Phone
Name of Contact *(if other than client)*	Relationship	Phone
Most Responsible Diagnosis		Date of Onset *(yyyy-Mon-dd)*

Client must have one or more of the following ***(check all that apply)***

☐ Physical Impairment *(specify details)*

☐ Visual Impairment *(specify details, attach any visual assessments already completed including visual field assessment)*

☐ Complex Cognitive Impairment that is stable or improving *(specify details, attach assessment if completed)*

Do you believe this client has potential to drive?	☐ Yes	☐ No
Is the client ready to drive now?	☐ Yes	☐ No
Has the client previously completed a driving assessment?	☐ Yes	☐ No
Is the client a novice driver?	☐ Yes	☐ No
Is the client a primary wheelchair user?	☐ Yes	☐ No
Does the client have any behavior or mental health concerns?	☐ Yes	☐ No
If yes, describe/attach details _____		
Is the client WCB?	☐ Yes	☐ No

Physician Name		Signature
Phone	Fax	Date *(yyyy-Mon-dd)*