



**Driver Evaluation and Training Service (DETS)  
Referral**

**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.

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.

**Incomplete referrals will be sent back to referring source.**

Client's Name <i>(last, first)</i>		Date of Birth <i>(yyyy-Mon-dd)</i>
Address	Postal Code	Phone
Name of Contact <i>(if other than client)</i>	Relationship	Phone
Most Responsible Diagnosis		Date of Onset <i>(yyyy-Mon-dd)</i>
<b>Client must have one or more of the following <i>(check all that apply)</i></b>		
<input type="checkbox"/> Physical Impairment <i>(specify details)</i> <hr/> <hr/>		
<input type="checkbox"/> Visual Impairment <i>(specify details, attach any visual assessments already completed)</i> <hr/> <hr/>		
<input type="checkbox"/> Complex Cognitive Impairment that is stable or improving <i>(specify details)</i> <hr/> <hr/>		
Do you believe this client has potential to drive?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the client ready to drive now?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the client a new driver?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the client a primary wheelchair user?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the client have any behavior or mental health concerns?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, describe/attach details _____		
Is the client WCB?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Physician Name		Signature
Phone	Fax	Date <i>(yyyy-Mon-dd)</i>