

## UK HDI Driver Rehabilitation Program Application

---

### Applicant Information

Full Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Email Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Alternate Contact Name (optional): \_\_\_\_\_

Alternate Contact Phone: \_\_\_\_\_

Home Address:

---

Driver's Permit or License Number: \_\_\_\_\_

Gender (optional): \_\_\_\_\_

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

---

## Medical Information

1. What medical condition or diagnosis do you have?

---

If you have a spinal cord injury, please answer below:

Injury level: \_\_\_\_\_

Date of diagnosis: \_\_\_\_\_

Type:  Incomplete  Complete

2. Has your doctor said you are medically stable?

Yes  No  Not sure

3. List all medicines you are take now (or write "none"):

---

---

4. Have you had a seizure in the last 6 months?

Yes  No

If yes, date of last seizure: \_\_\_\_\_

## Driver's License and Driving History

5. Do you have a valid driver's license or learner's permit?

Yes  No

*Important: We cannot schedule an appointment until you have a valid permit or license.*

Has your license ever been suspended, revoked, or sent to the Medical Review Board?

Yes  No

6. Do you currently drive?

Yes  No

If no, when did you stop driving? \_\_\_\_\_

7. About how many miles do you drive in one year?

\_\_\_\_\_ miles

## **Vehicle and Driving Equipment**

8. Do you use any special driving equipment or vehicle modifications?

Yes  No

If yes, list the equipment and brand:

---

9. What type(s) of vehicle do you drive or plan to drive?

Car  SUV  Truck  Van

10. Is this evaluation needed because your vehicle requires modification updates?

Yes  No

## **Vision and Brain Health**

11. Do you have any vision problems that affect driving?

Yes  No

If yes, please describe:

---

12. Do you have double vision?

Yes  No

13. Have you been told you have hemianopsia (loss of vision on one side)?

Yes  No

If yes, please include vision test results if available.

14. Do you get tired easily or have trouble with endurance?

Yes  No

If yes, please explain:

---

## Physical Abilities

15. Can you control and move your arms well enough to drive?

Yes  No

16. Can you control and move your legs well enough to drive?

Yes  No

17. Is one side of your body stronger than the other?

Left arm  Right arm  Left leg  Right leg

18. Do you have steady strength in your hands?

Yes  No

19. Do you have steady strength in your shoulders?

Yes  No

20. Are you able to walk at least short distances?

Yes  No

If yes, about how far can you walk at one time?

---

## **Mobility Equipment**

21. Do you use a wheelchair?

Yes  No

If yes:

Manual wheelchair  Power wheelchair

Brand (if known): \_\_\_\_\_

22. Do you use a scooter?

Yes  No

If yes, type or brand: \_\_\_\_\_

## **Transfers and Access Needs**

23. Have you been seen in this office before?

Yes  No

24. Can you move from your wheelchair or scooter into the driver's seat?

Yes  No

25. Do you need a level surface to transfer safely?

Yes  No

26. Can you get in and out of an SUV or truck on your own?

Yes  No

## Scheduling Information

Office hours are Monday through Friday, 8:00 a.m. to 5:00 p.m.

Do you have any days, times, or needs we should know about when scheduling your appointment?

## Funding Source – Choose One Option Below

**Self-Pay**

If you choose Self-Pay, you are responsible for paying for your services.

UKHDI does *not* file claims with private health insurance.

If you want to use private insurance, you must pay at the time of service and then file for reimbursement on your own.

**Workers' Compensation**

For Workers' Compensation or Trust payors, UKHDI requires prior authorization.

Case Manager Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Fax: \_\_\_\_\_

**Vocational Rehabilitation or Veterans Administration**

These payors also require prior authorization.

Counselor Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_