



**KINETIK DRIVER EVALUATION PROGRAM**  
 8TH FLOOR, SASKATOON CITY HOSPITAL  
 701 QUEEN STREET, SASKATOON, SK, CANADA S7K 0M7  
 TEL (306)655-8612 FAX (306)655-7878

Referral Date: \_\_\_\_\_

**Client Information:**

Client name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address (street, city, postal code): \_\_\_\_\_

DOB/Age: \_\_\_\_\_ PHN \_\_\_\_\_ Sex: \_\_\_\_\_

Family Physician \_\_\_\_\_

Consent to contact family physician      yes/no      date/signature \_\_\_\_\_

Been seen at: SCH RUH SPH Other \_\_\_\_\_

Consent to obtain medical charts (rehab/GAU/RUH)      yes/no

from \_\_\_\_\_ date/signature \_\_\_\_\_

Agencies presently involved: ABI SGI WCB HTB GAU KCC Rehab Other \_\_\_\_\_

Consent to communicate with agency contact person      yes/no

Name \_\_\_\_\_ date/signature \_\_\_\_\_

Driver license: valid/invalid/suspended/never driven      class \_\_\_\_\_ lic# \_\_\_\_\_

Currently driving      yes/no

Need Hand controls / other adaptive equipment      yes /no

Fee payment by \_\_\_\_ self pay      \_\_\_\_ SGI      \_\_\_\_ WCB      \_\_\_\_ other

**Referral Source:**

Circle one: Self Physician ABI SGI WCB FIT Rehab Other \_\_\_\_\_

Contact name: \_\_\_\_\_ phone: \_\_\_\_\_

Address (street, city, postal code): \_\_\_\_\_

**Reason for referral:** (Circle all relevant)

Arthritis stroke brain injury spinal cord injury dementia Cerebral Palsy  
 Vision problems, Other (neurological/medical/physical problem) \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Other Relevant information:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Appointment date _____	Time _____	Family physician _____
Appointment letter mailed _____	Appointment date written in Book _____	