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OCCUPATIONAL THERAPY DRIVING ASSESSMENT REFERRAL

DATE OF REFERRAL: / /

CLIENT DETAILS:

Name:_____ **D.O.B.** _____

Address: _____

Phone: (H)_____ **(M)**_____

REFERRER DETAILS:

Name:_____ **Phone:** _____

Address:_____

GENERAL PRACTITIONER (If different from Referrer):

Name: _____ **Phone:** _____

Practice:_____

MEDICAL HISTORY:

Reason for referral:_____

Diagnosis & Date of Onset:_____

Other Medical History: (attach medical summary if available)_____

_____

_____

Please tick any of the following conditions that are relevant to the client

❑ Dementia > 24 months	❑ Epilepsy	❑ Cardiac Arrest with chance of recurrence
❑ NIDDM / IDDM	❑ Recent CVA / TIA	❑ Other Cardiac Condition _____
❑ Acquired Brain Injury	❑ Multiple Sclerosis	❑ Amputee_____
❑ Parkinson's Disease	❑ Intracranial Surgery	

Current Medications: _____

_____

_____

CURRENT FUNCTIONAL STATUS:

Cognition: impaired / not impaired_____

Visual Acuity:_____

Note: Austroads (2003): 6/12 Binocular Visual Acuity Required)

Visual Fields:_____

Note: Austroads (2003): Must have at least 120 degrees of vision along the horizontal meridian

IF QUADRANTANOPIA OR HEMIANOPIA: RECOMMEND NOT TO DRIVE. FORMAL OPHTHALMOLOGICAL/PERIMETRY TESTING IS REQUIRED PRIOR TO DRIVING ASSESSMENT.

Physical: impaired / not impaired_____

_____

BEHAVIOUR:

Are there any concerns regarding the client's ability to control anger / emotions? YES / NO

Attitude towards assessment: ❑ compliant ❑ resistant ❑ hostile

COMMUNICATION:

Expressive / Receptive: impaired / not impaired _____

Needs an Interpreter: Yes / No Language:_____

DRIVING HISTORY:

Current Drivers Licence: Yes / No Licence No.:_____ **Expiry Date:** _____

Licence Conditions: _____

Current Vehicle(s) Driven: _____

Assessment Vehicle Requirements: Manual / Automatic_____

Other Comments / Additional Information:

_____

_____

_____

MEDICAL CLEARANCE FOR OCCUPATIONAL THERAPY DRIVING ASSESSMENT

- **Treating Doctor to complete below**

I, _____ (doctor) state that _____

(client) is medically fit to undertake an Occupational Therapy Driving Assessment and, if indicated, participate in an Occupational Therapy Driving Remediation Programme.

Doctor's Signature: _____ Date: _____