

OCCUPATIONAL THERAPY DRIVING ASSESSMENT REFERRAL

Client details:

Name: _____

Address: _____

Phone: _____ D.O.B: _____ Funding Type: _____

General Practitioner/Referrer details:

Name: _____

Practice: _____

Email: _____

Phone: _____ Date of referral: _____

Reason for referral:

Driver Details: Must hold a valid licence

Drivers Licence: Type: _____ Licence No: _____ Expiry Date: _____

Licence Conditions: ☐ A (automatic transmission) ☐ S (spectacles to be worn)

☐ V (vehicle modifications) ☐ M (medical condition); If yes, med cert expiry date: _____

☐ Other: _____

Assessment Vehicle Requirements: ☐ Manual ☐ Automatic

Medical History:

Diagnosis and Date of Onset: _____

Current Medications: _____

Cognition: ☐ Impaired ☐ Not impaired _____

Visual Perception: ☐ Impaired (Please include Optometrist report if relevant) ☐ Not impaired _____

Physical: ☐ Impaired ☐ Not impaired _____

Other: _____

Driving Assessment Risk Screening

The following medical conditions may affect safe driving. Please indicate any that apply:

- ☐ Alcohol And Other Substance Misuse _____
- ☐ Blackouts _____
- ☐ Cardiovascular Conditions _____
- ☐ Dementia And Cognitive Impairment _____
- ☐ Diabetes _____
- ☐ Musculoskeletal Conditions _____
- ☐ Neurological Conditions _____
- ☐ Psychiatric Conditions _____
- ☐ Seizures And Epilepsy _____
- ☐ Sleep Disorders _____
- ☐ Vision And Eye Disorders _____

Indicate previous accidents or near misses _____

Behaviour: Are there concerns regarding patient ability to control anger/emotions? ☐ Yes ☐ No

What advice you have provided to your patient regarding their driving status whilst assessment pending?

- ☐ Must not drive whilst awaiting OT driving assessment
- ☐ May continue to drive whilst awaiting OT driving assessment
- ☐ May drive with conditions (list) whilst awaiting OTDA: _____

***Please ensure QLD Transport Medical Certificate (F3712) has been completed, and Part 2, Option B 'Only for the purpose of an occupational therapy driving assessment or lesson' is selected if they must wait for assessment before continuing to drive.**

Assessment Booking Contact:

☐ Client directly ☐ Contact Doctor for further info ☐ Contact NOK _____

Medical Clearance for OT Driving Assessment:

I _____ certify that my patient _____

is medically fit to undergo an occupational therapy driving assessment.

Signed: _____