**OCCUPATIONAL THERAPY**
**DRIVING ASSESSMENT REFERRAL FORM**

| **Surname** | **Given Names** | **Address:** | **DOB** |
|---|---|---|---|
| | | | |

| **General Practitioner Name:** | **Phone Number:** |
|---|---|
| | |

| **Medical History / Medical Conditions:** | | | |
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| **Medications:** | | | |
|---|---|---|---|
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**Current Functional Status:**

Cognition: ☐ Impaired ☐ Not Impaired

Details:

Physical: ☐ Impaired ☐ Not Impaired

Details:

**Behaviour:**

Are there any concerns regarding the client's ability to control anger/emotions? ☐ Yes ☐ No

Attitude towards assessment
- ☐ Understanding / compliant
- ☐ Resistant
- ☐ Hostile

**Visual Acuity / Field requirements:**

**Acuity:** _____

*(Austroads (2012): 6/12 Binocular Visual Acuity required)*

**Field:** _____

(*Austroads (2012): Must have at least 110 degrees of vision along the horizontal meridian and within 10 degrees above and below the midline)*

***If quadrantanopia or hemianopia: Recommended not to drive. Formal ophthalmological/perimetry testing is required prior to driving assessment***.

**Communication: Needs Interpreter: Yes / No Language:**

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**Driving History:** *Please note that the client must hold a valid licence or learner's permit.*

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

Licence Conditions: ☐ A (auto only) ☐ S (spectacles to be worn) ☐ V (vehicle modifications)

☐ M (medical condition); If yes, current medical certificate expiry date: _____

☐ Other: _____

Current Vehicle(s) Driven: _____

Assessment Vehicle Requirements: ☐ Manual ☐ Automatic

**Driving Assessment Risk Screening – *NB This field is Mandatory***

The following criteria may increase the risk of unsafe driving. To assist us in managing the referral, please complete the following checklist.

**If multiple factors are ticked please contact Occupational Therapy for advice BEFORE progressing this referral.**

☐ Co morbidity of the following diagnoses as per evidence/Austroads Guidelines (2012):

- ☐ Dementia >24 months
- ☐ Parkinson's disease
- ☐ Epilepsy
- ☐ NIDDM or IDDM
- ☐ Recent stroke or TIA
- ☐ Post intracranial surgery
- ☐ Significant acquired brain injury
- ☐ Multiple sclerosis
- ☐ Cardiac arrest with chance of recurrence or other heart condition

☐ Attention deficits

☐ Use of Benzodiazepines or Tricyclic antidepressants

☐ Previous close calls / accidents reported. If yes, please describe _____
_____

**Urgency of referral:**

☐ Urgent- public safety risk

☐ Requires appointment according to regular system of availability/ waiting list

Please indicate below what advice you have provided to your client regarding their driving status whilst awaiting assessment.

☐ Must not drive whilst awaiting OT driving assessment

☐ May continue to drive whilst awaiting OT driving assessment

☐ May drive with conditions (list) whilst awaiting assessment:

**Medical Clearance for Occupational Therapy Driving Assessment:**

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: _____