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| **FM.RF.009 - Occupational Therapy Referral Form - Driving Assessment**  |
| **Date:**  |  |
| **Client name:** |  |
| **Client DOB: DD/MM/YYYY** |  |
| **Client contact details:** | **Phone:Email:** |
| **Client home address:** |  |
| **PAYMENT for assessment:** * **Funding Body**
* **Private**
 | Details (Company, company contact, Billing details)………………………………………………………………………………. ………………………………………………………………………………. Client’s billing details (full name, address, email, contact number): ………………………………………………………………………………. ……………………………………………………………………………….  |
| **Relevant medical information:**  (e.g. Diagnosis, medical history, date of onset, current medications, mental health status) |  |



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| **Behaviour:**  | **Are there any concerns regarding the client’s ability to control anger and/or emotions:** * Yes
* No

**The client’s attitude towards the OT driving assessment:** * Understanding
* Compliant
* Resistant
* Hostile
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| **Current level of function:**  | **Physical*** Impaired
* Not impaired

**Vision** * Impaired
* Not impaired

**Cognition** * Impaired
* Not impaired

**Hearing** * Impaired
* Not impaired

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| **Licencing information:**  | **Current drivers’ licence?** * Yes - Licence No: …………………..………………….. Expiry Date: ……………………….
* No

**Licence conditions:** ………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………**Vehicle transmission for assessment:*** Automatic
* Manual
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| **Any required vehicle modifications (if known):**  |  |



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

* Must not drive awaiting OT driving assessment
* May continue with drive whilst awaiting OT driving assessment
* May drive with conditions (please list) whilst awaiting OT driving assessment
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**Checklist of required documents prior to assessment:**

* Copy of current in date licence / or Queensland Gov. Medical Certificate for Motor Vehicle Driver (F3712) - <https://www.support.transport.qld.gov.au/qt/formsdat.nsf/forms/QF3712/>
* Current Optometry Report (includes computerised Perimetry Testing)
* Any relevant medical reports (e.g.; Neuropsychology report)

## REFERRING PERSONNEL:

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| **Name:Company: Email:Phone:**  | **Signature:** | **Date:** |