DriverRehab

Occupational Therapy Driver Assessment Referral Form

CLIENT DETAILS

Name:_____

DOB:_____

Address:_____

_____

Contact number:_____

Email:_____

Next of Kin:_____

Contact number:_____

Reason for referral:

Fitness to drive: ☐ Modifications:

First time driver: ☐ Heavy vehicle: ☐

Diagnosis/Disability:

_____

Date of onset:_____

GP:_____

Medications:_____

_____

Functional impact on driving

Vision:_____

Physical and sensory:_____

_____

Cognition:_____

_____

Communication:_____

_____

Behaviour:_____

Is the client aware of this referral: Y ☐ N ☐

LICENCE DETAILS

Licence No.:_____

Expiry date:_____

Classes:_____

Manual: ☐ Auto: ☐

FUNDING

Disability equipment grant: ☐ NDIS: ☐

DVA: ☐ Worker's compensation: ☐

Medicare EPC: ☐

REFERRER INFORMATION

Name:_____

Title:_____

Organisation:_____

_____

Address:_____

_____

_____

Contact number:_____

Fax:_____

Email:_____

Is the client fit to undertake Occupational Therapy Driver Assessment:

Y ☐ N ☐

Referrer Signature:_____

Date:_____

Please complete this form and fax it to (08) 6314 6658 or email otda@driverrehab.com.au