DriverRehab

Occupational Therapy Driver Assessment Referral Form

CLIENT DETAILS

Name:_____ DOB:_____

Address:_____

Contact number:_____ Email:_____

Alternative contact:_____ Contact number:_____

Reason for referral: Fitness to drive ☐ Vehicle modification ☐ First time driver ☐ Heavy vehicle ☐

DIAGNOSIS/DISABILITY:

Medical condition/Disability _____ Date of onset:_____

GP:_____ Medications:_____

LICENCE DETAILS

Licence/Permit No:_____ Classes:_____ Expiry date:_____

Manual: ☐ Auto: ☐

FUNCTIONAL IMPACT ON DRIVING

Vision:_____ Hearing:_____

Physical and sensory:_____

Cognition and behaviour:_____

FUNDING INFORMATION

NDIS ☐ Home Care Package ☐ DVA ☐ Worker's compensation ☐

Medicare EPC: ☐ (Medicare EPC referral form must be attached) ICWA ☐

NDIS PARTICIPANTS

NDIS number: _____ Plan dates: _____

Agency managed ☐ Self-managed ☐ Plan managed ☐

REFERRER INFORMATION

Name:_____ Contact number:_____

Organisation:_____ Email:_____

Is the client fit to undertake Occupational Therapy Driver Assessment: Y ☐ N ☐

Tick if electronic copy of report is preferred. ☐

Referrer Signature:_____ Date:_____

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

www.driverrehab.com.au

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