NorthCoast Rehab Services
Occupational Therapy Driving Assessment's Referral Form
p: 07 5446 8289 f: 07 5446 7666 ACN 139 435 671
e: reception@northcoastrehab.com.aue: PO Box 397, Yandina QLD 4561
mo: northcoastservices

North Coast Rehab Services Referral Form

- to be completed by Medical Practitioner

Name: **D.O.B:**

Address:

Phone:

GP/ Specialist details:

Name:

Phone:

Fax:

Email:

Funding Body – Please circle: Self / My Aged Care Plan / Insurer / NDIS / My Aged Care Plan

Identifier: _____

Details for invoices: _____

Note: DVA will not pay for Driving Assessments.

Reason for referral: (Please see attached list of appropriate reasons)

Medical History:
Diagnosis:

Date of onset:

Please note: If history of stroke – please ask client to get their visual fields tested through automated perimetry machine at optometrist and send a copy of report and interpretation to us.
If history of Acquired Brain Injury or head trauma- please make comment if had history of seizures and that their condition is now stable as per Austroads Medical Guidelines.

Cognition: impaired / not impaired

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Physical Function: impaired/ not impaired

Vision:
Acuity:
(Austroads Medical Guidelines: 6/12 Binocular Visual Acuity required)

Visual Fields:
Austroads Medical Guidelines: (Must have at least 120 degrees of vision along the horizontal meridian).
CVA & Acquired Brain Injuries- Esterman Binocular is required.

Driving History:

Current licence (if known): Yes ☐ No ☐
If no, is licence Suspended- (Medically or legally?)/ revoked/ or cancelled?

Licence nNumber: _____expiry date_____

Licence Type: _____

Licence Class: _____

Conditions or Restrictions? _____

Desired licence class: _____

Is the patient currently driving Yes ☐ No ☐

Has the patient been advised to cease driving? Yes ☐ No ☐

Behaviour:

Are there any concerns regarding the client's ability to control anger/emotions? Yes ☐ No ☐
Attitude towards assessment: Understanding ☐ Resistant ☐

Contact Process

☐ Contact client directly for appointment
☐ Contact referrer for further direction
☐ Other: _____

Is patient aware of referral: Yes ☐ No ☐

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Communication

Is an interpreter required? Yes ☐ No ☐
If yes, Language? _____

Additional Information: (mental health, communication needs, cognition, impulsivity, mobility, hearing, vision etc)

Medical Clearance for Occupational Therapy Driving Assessment:

I, _____ (Doctor / General Practitioner)

state that_____ (Client) is medically fit to undertake an Occupational Therapy Driving Assessment and, if indicated, participate in an Occupational Therapy Driving Remediation Program.

Doctor's Signature: _____ Date: _____

Doctor's Stamp:

Please attach a Patient Health Summary to this referral.

Appropriate reasons for OT Driving Assessment

- Older clients with general frailty/ageing, physical/functional problems, memory loss etc
- Clients with chronic health conditions e.g. Functional impairments caused from diabetes e.g peripheral neuropathy ie. Numbness in feet.
- Clients with neurological conditions e.g. stroke, Parkinson's, spinal cord injury
- Clients with orthopaedic injuries e.g. amputations, hand and shoulder injuries, back injuries
- Younger/learner drivers with physical impairments such as cerebral palsy, spinal cord injury
- Younger/learner drivers with learning difficulties e.g. Asperger's and Autism