



east coast
DRIVER REHAB

ANITA COMPTON

DRIVER TRAINED OCCUPATIONAL THERAPIST

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OCCUPATIONAL THERAPY DRIVING ASSESSMENT

Patient details:

Name: _____

Address: _____

Phone: _____ D.O.B: _____

Referrer details:

Name: _____ Phone: _____

Address: _____

Doctor / General Practitioner (if different from Referrer):

Name: _____ Phone: _____

Address: _____

Email: _____ Fax: _____

Reason for referral: _____

Medical History:

Diagnosis and Date of Onset: _____

Current Medications: _____

Cognition: impaired / not impaired _____

Physical: impaired / not impaired _____

Visual (if known):

Acuity: _____

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

Field: _____

(Austroads Medical Guidelines: Must have at least 120 degrees of vision along the horizontal meridian).

Driving History

Current Licence (if known): YES / NO Licence No: _____ Expiry Date: _____

Licence Conditions: _____

Is the patient currently driving? YES / NO

Behaviour:

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

Attitude towards assessment

☐ Understanding / compliant

☐ Resistant

Contact Process

☐ Contact client directly for appointment

☐ Contact referrer for further direction

☐ Other: _____

Is patient aware of referral:

Yes ☐

No ☐

Communication

☐ Interpreter required:

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: _____