OCCUPATIONAL THERAPY BRISBANE

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OCCUPATIONAL THERAPY COGNITIVE FITNESS TO DRIVE CONSULTATION REFERRAL
An In Room Assessment Only

Client details:

Name: _____

Address: _____

Phone: _____ D.O.B: _____

Funding: _____

Referrer details:

Name: _____

Address: _____

Phone: _____

General Practitioner (if different from Referrer):

Name: _____

Address: _____

Phone: _____

Date of referral: _____

Reason for referral: _____

Driving History: *Please note that the client must hold a valid licence or learner's permit.*

Drivers Licence: Type: _____ Licence No: _____ Expiry Date: _____

Licence Conditions: ☐ A (auto only) ☐ S (spectacles to be worn) ☐ V (vehicle modifications)

☐ M (medical condition); If yes, current medical certificate expiry date: _____

☐ Other: _____

Current Vehicle(s) Driven: _____

Medical History: Medical Summary Attached ☐ Yes ☐ No

Diagnosis and Date of Onset: _____

Current Medications: _____

_____

Current Functional Status:

Cognition: impaired / not impaired _____

Visual Perception: impaired /not impaired _____

_____

Physical: impaired / not impaired _____

_____

Vision Assessment: *Please provide current visual acuity assessment results R/L Both*

_____

Hearing/ Other:

Driving Assessment Risk Screening – *NB This field is Mandatory*

The following criteria may increase the risk of unsafe driving. To assist us in managing the referral, please complete the following checklist.

If multiple factors are ticked please contact Occupational Therapy for advice BEFORE progressing this referral.

☐ Co morbidity of the following diagnoses as per evidence/Austroads Guidelines(2012):

- ☐ Dementia >24 months
- ☐ Parkinson's disease
- ☐ Epilepsy
- ☐ NIDDM or IDDM
- ☐ Recent stroke or TIA
- ☐ Post intracranial surgery
- ☐ Significant acquired brain injury
- ☐ Multiple sclerosis
- ☐ Cardiac arrest with chance of recurrence or other heart condition

☐ Attention deficits

☐ **Active Mental Health Condition ** Please note patients with an active mental health condition are not eligible for this consultation ****

☐ Use of Benzodiazepines or Tricyclic antidepressants

☐ Previous close calls / accidents reported. If yes, please describe_____

_____

Urgency of referral:

☐ Urgent- public safety risk

☐ Requires appointment according to regular system of availability/ waiting list

A waiting list may exist for In Room OT Driver Screening.

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

☐ Must not drive whilst awaiting OT driver screening ☐ May continue to drive whilst awaiting OT driver screening ☐ May drive with conditions (list) whilst awaiting OT driver screening: _____

_____

Behaviour:

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

Attitude towards assessment

☐ Understanding / compliant

☐ Resistant

☐ Hostile

Contact process:

☐ Contact client directly for appointment

☐ Contact referrer for further direction

☐ Other:

Medical Clearance for OT Driving Assessment

I _____ certify that my patient _____ is medically fit to undergo an in room occupational therapy driver screening consultation.

Signed: _____

Please include visual acuity assessment results if completed