

REFERRAL FORM: Occupational Therapy Driving Assessment

Person's Details

Name			Date of birth	
Address				
Contact number		Email		
Support person's name and contact details				

Reason for assessment

Is the assessment needed to determine:	☐ fitness to drive* ☐ need for modifications ☐ to determine eligibility for funding for lessons
Diagnosis /disability & date of onset if applicable	
Impairments (any physical/ sensory/ cognitive/ mood or behaviour difficulties)	

License details (if known)

License number		Expiry date		License Class	
Current vehicle (make, model, auto/ manual)					

Referrer Details

Name	
Position	
Organisation	
Contact details	
* Medical practitioner's signature	
Date of referral	

* When the Occupational Therapy Driving Assessment is to determine someone's fitness to drive the referral must be signed by a medical practitioner.

Please send completed referrals to: gill.driveperth@gmail.com