

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: steve.driveperth@gmail.com