Occupational Focus
Occupational Therapy & Injury Management Consulting
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REFERRAL FOR OCCUPATIONAL THERAPY DRIVER ASSESSMENT / REHABILITATION

CLIENT DETAILS

Client Name:	
Address:	
Telephone:	Mobile:
Date of Birth:	
Occupation:	
Interpreter Required: Yes ☐ / No ☐	Language spoken:
Next of Kin:	Relationship:
Next of Kin Contact Details:	Contact: Yes ☐ / No ☐

TREATING DOCTOR

☐ General Practitioner	☐ Specialist
GP/Dr Name:	
Address:	
Telephone:	Fax:

REFERRER DETAILS

Name:	
Position:	
Company:	
Address:	
Telephone:	Fax:
Email:	

REASON FOR REFERRAL

☐ New medical condition or injury impacting on driving	☐ Progression of existing condition impacting on driving
☐ New / Learner Driver with medical condition	☐ Age related deterioration
☐ Vehicle modification or aids	☐ Other (Please detail):

CLIENT LICENCE DETAILS AND DRIVING INFORMATION

Current Licence: Yes ☐ / No ☐	Licence No:	Expiry Date:
Driving Experience: Yes ☐ / No ☐		Years of Experience:
Is the client currently driving: Yes ☐ / No ☐		Date last driven:
Attitude towards referral: Positive / Negative / Non-committal		

MEDICAL INFORMATION (Please attach relevant medical reports where appropriate)

Diagnosis:

Date of onset:

Past Medical History:

Current Medications:

Compliance with medications: Yes ☐ / No ☐

Current Treatment:

Vision: Normal ☐ / Impaired ☐

Optometrist Report Attached: Yes ☐ / No ☐

Hearing: Normal ☐ / Impaired ☐

Communication:

PLEASE FILL IN THE INFORMATION BELOW ONLY IF IT IS RELEVANT TO THE DIAGNOSED CONDITION OR LIMITATION

PHYSICAL IMPAIRMENT (provide further detail as appropriate)

Range of Movement: Normal ☐ / Limited ☐	**Muscle Strength:** Normal ☐ / Limited ☐
Muscle Tone: Normal ☐ / High ☐ / Low ☐	**Co-ordination:** Normal ☐ / Impaired ☐
Sensation: Normal ☐ / Impaired ☐	**Balance:** Normal ☐ / Impaired ☐
Mobility: Normal ☐ / Impaired ☐	**Pain:** Yes ☐ / No ☐
Mobility aids used:	

Details:

COGNITION (provide further detail as appropriate)

Concentration: Normal ☐ / Impaired ☐	**Perception:** Normal ☐ / Impaired ☐
Memory: Normal ☐ / Impaired ☐	**Planning:** Normal ☐ / Impaired ☐
Judgement: Normal ☐ / Impaired ☐	**Insight:** Normal ☐ / Impaired ☐

Details:

Does the client's condition cause fluctuations in physical/cognitive states: Yes ☐ / No ☐

Mental Health Status:

Behaviour (Anxiety, Confidence, Flexibility, Aggression, Initiation):

Other Comments:

Medical Clearance for OT Assessment: Yes ☐ / No ☐

VicRoads Medical Report Form: Sent to VicRoads ☐ / Copy attached ☐

REFEERER TO COMPLETE (Relevant only for Insurer/Compensable Referrals)

Payment Classification codes to be used:

No of Hours Approved:

Signature:	Date:
Name:	Title:

By sending this referral the referrer acknowledges that any work completed will incur costs for services provided, and the referrer has the relevant authority and approval to refer for requested services.

Signature: **Date:**

THANK-YOU FOR TAKING THE TIME TO COMPLETE THIS REFERRAL FORM.

Please fax to 03 8692 2898 or email to: info@occupationalfocus.com.au

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