ATZ Driving Solutions
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OCCUPATIONAL THERAPY DRIVING ASSESSMENT REFERRAL

Name:		**Date of Birth** / /
Street address:	**Home phone number:**	**Mobile number:**
Funding: Private/NDIS/CTP/DVA/EPC/iCare/Other If NDIS, is Plan managed by: Agency/Self/External Plan number: _____ expiry:		**Contact Email:**

Is person aware of referral? ❑ Yes ❑ No
If no, who should we contact-
Contact details:

REASON FOR REFERRAL

❑ Potential to Drive assessment required - person has no driving licence

OR

❑ Fitness to Drive Assessment required - RMS Medical completed and lodged ❑ Yes ❑ No

Presenting concern:

Date of presenting concern/injury: _____/_____/_____

Medical History: *(Attach health summary if preferred)*

Current medications:

GP Name: _____ **Practice:** _____ **Address:** _____ **Phone:** _____ ❑ Is GP aware of referral (if not referrer)	**Referral source (if not GP)** **Name:** _____ **Phone:** _____ **Email:** _____ **Relationship to client:**

DRIVING HISTORY

Licence details Class: LRN/R/C/LR/MR/HR/HC/MC **Licence No**: _____ **Expiry Date**: _____

Current Vehicle: _____ ❑ Manual ❑ Automatic
Other relevant information: (Include if you are aware of any close calls/recent accidents)

URGENCY OF REFERRAL

- ❑ Must be completed ASAP - person poses risk to local community
- ❑ Requires appointment prior to licence suspension/renewal in line with medical reporting
- ❑ No urgency - assessment is required for data gathering and supporting documentation

ATZDS will take this information into consideration and advise of the date of appointment (no appointment can be confirmed until medical clearance, funding approval and licence check has been completed).

In the interim, please advise what information has been provided to the client:

- ❑ Must not drive until Occupational Therapy driving assessment completed
- ❑ Recommend only drive with family member or within immediate area
- ❑ No conditions or recommendations provided

Please list any attachments to this referral-

The above information is true to the best of my knowledge. I understand that ATZDS reserves the right to triage this referral and that no reports will be released until account is paid to ATZ Driving Solutions. I understand that medical clearance and a current licence is required before the practical on road assessment can take place, and I also authorize ATZ Driving Solutionsto obtain medical /driver's licence information as required to coordinate this driving assessment if I am unable to provide with this referral.

Referrer name: **Signature:**	**Date:** _____/_____/_____

MEDICAL CLEARANCE FOR OT DRIVING ASSESSMENT

*Only to be completed by treating GP of referred patient.

ATZDS require the treating GP to provide medical clearance that they believe their patient is fit to undergo the OT Driving Assessment. Please note, this is directly and only in relation to the practical onroad driving component of the OT assessment. If the treating GP is not completing this referral, ATZDS will follow up the medical clearance required prior to assessment.

I, _____ certify that my patient _____
is medically fit to undergo an Occupational Therapy Driving Assessment.

Signed: _____ **Date**: _____/_____/_____