Capital Health

Occupational Therapy Services

# Driver Evaluation Program Referral

Fax #: 473-1321

Patient Name ______________________
Support/Contact Person ______________Ph________
Date of Birth: YY ______ MM _____ DD ______
Address: ______________________
Phone: (Home)____________ (Work)____________
Family Physician: ______________________
Health Card No: ______________ Exp. date________
HUN: ______________________

**Date of Referral**: ______________________

**Contact Person**: ______________________ Phone: ______________

**Diagnosis/Prognosis**: ______________________

**Pertinent Medical History/Other Health Concerns**: ______________________

**Purpose for Driving**: ☐ Work ☐ Community Access ☐ Leisure ☐ Other ______________
Estimated return to work date: ______________
Indicate alternate modes of transportation: ☐ None ☐ Taxi ☐ Public transport/bus ☐ Family/friend

**Has the client's license been formally suspended?** ☐ Yes ☐ No

**Has the client been advised not to drive until this assessment is completed?** ☐ Yes ☐ No

**RELEVANT MEDICAL HISTORY:** Please thoroughly investigate and report on the following:
Cardiovascular disease ______________________
Cerebrovascular disease ______________________
Peripheral vascular disease ______________________
Spinal cord injury level ______________________
Neurological disorder ______________________
Musculoskeletal disability ______________________
Visual Impairment ______________________
Other ______________________
Seizure activity* no _____ yes _____ date of last (yyyy/mm/dd) ______________
Present medications** ______________________

* Seizure activity - please note medical standards related to driving after seizure activity.
** Present medications - please note it is the physician's responsibility to determine effects on driving.

Referral Forms

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**COGNITIVE STATUS (if applicable)**

Perceptual ______________________________________________________________

______________________________________________________________

Memory ______________________________________________________________

Problem Solving ______________________________________________________________

Personality/Behavioral changes ______________________________________________

Insight ______________________________________________________________

Standardized test results: (please include dates of administration)

MMSE ______________________________ MoCA ______________________________

Trails A ______________________________ Trails B ______________________________

MVPT ______________________________ Sunnybrook Bedside Neglect Battery ______________

UFOV ______________________________ Other ______________________________

**FUNCTIONAL DISABILITY:** ______________________________________________

**DRIVING PROBLEMS EXPECTED:** ______________________________________________

**ADDITIONAL COMMENTS** ______________________________________________

______________________________________________________________

______________________________________________________________

**CLIENT READY TO BE CONTACTED:** ☐ 2 - 4 weeks ☐ 2 - 3 months ☐ Other ______________

* Please Note - Referral will be prioritized according to established Occupational Therapy Department guidelines. Wait times will vary and may be greater than three months.

**PROFESSIONALS INVOLVED WITH CLIENT** (Please provide names)

☐ Occupational Therapist ____________________________ ☐ Other(s) ______________________

**REFERRING PHYSICIAN** (Please print)* A physician's signature is required for driver evaluation

Name ________________________________________ Signature ____________________________

Phone Number ________________________________

**Please note: This is not a simulated driving assessment. An on road evaluation will be completed with all clients deemed appropriate.**