Drive Able
Occupational Therapy

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# Occupational Therapy Driver Assessment Referral

## CLIENT INFORMATION

Name: D.O.B:

Address:

Phone: Email:

Current drivers' license: Yes No

## MEDICAL INFORMATION

Diagnosis/recognized disability & relevant medical history:

GP Name:

GP Clinic:

## FUNDING INFORMATION

Self-Funding NDIS Aged Care Package Other

Claim / NDIS No.

If NDIS, please provide fund management details below and include a copy of participant plan

Plan Managed

Name of Plan Manager:

Accounts Email:

Phone:

Self-Managed

Contact Name:

Accounts Email:

## Referrer Details

Name:

Relationship to client:

Phone: Email:

Referral Type:

OT Driver Assessment (full license)

OT Driver Assessment (learner)

Potential to Drive Assessment (unlicensed)

Vehicle Modification Assessment

Accessible Parking Permit Application

## Risk & Safety Assessment

| | | |
|---|---|---|
| Is anyone at the property known to be aggressive or violent? | Yes | No |
| Are there known firearms at the property? | Yes | No |
| Are dangerous pets or animals known to be at the property? | Yes | No |
| Does anyone at the property smoke? | Yes | No |
| Is there a known history of illicit drug use at the property? | Yes | No |

Are there other factors the Occupational Therapy Driver Assessor should be aware of?

Referrals to be emailed to **admin@driveableot.com.au**