Driving Occupational therapy services

For safe, active and independent living

OT DRIVER ASSESSMENT & REHABILITATION

Occupational Therapy Services Group provides a specialty service for people following a medical illness or injury which may have affected their ability to drive. This service aims to help people begin or return to driving safely and legally.

This can involve:

- Comprehensive Off Road Assessment
- Practical Driving Trial/ Assessment
- Driver Rehabilitation Program

Assessments are conducted by Occupational Therapists who have completed a post-graduate driver training qualification and are registered with the Australian Board of Occupational Therapy. These therapists will perform a detailed assessment (including: driving history; visual & neurophysical; cognitive & perceptual tests; on-road evaluation etc.) and document outcomes in a comprehensive report, outlining:

- ✓ How a person's medical condition may impact on their ability to drive
- ✓ Assess an aged person's ability to drive a vehicle (physical & cognitive capacity)
- ✓ Recommend appropriate vehicle modifications & provide training in their use
- ✓ Assess work related driving capacity
- ✓ Help an individual with an acquired or congenital disability begin driving
- ✓ Help identify alternative transport options to ensure the individual can access the community/ social networks and maintain his/her independence

West Australian Law requires that any individual who has sustained a medical illness or injury that may impact on their ability to drive is required to notify the Department of Transport (DOT) - www.transport.wa.gov.au/index.asp

TO REFER FOR THIS SERVICE:

1. COMPLETE THE ATTACHED REFERRAL FORM (GP or therapist)
2. FORWARD TO: info@drivingotservices.com OR FAX: (08) 9332 6548

Once the referral is received the client will be contacted within one to three working days. A comprehensive report will be sent to the Department of Transport, and the referrer (GP/therapist) following the assessment detailing recommendations.

For further information or to discuss this service, please contact:

CHRIS PEARCE: 0401 410 979
OFFICE: (08) 9332 1783
EMAIL: info@drivingotservices.com
WEB: www.drivingotservices.com
PO Box 254, Hamilton Hill, WA 6963

Please discuss subsidies/ rebates for this service with our staff.
Private Health Rebate Available (depending on ancillary cover). Medicare Enhanced Primary Care (EPC) Rebate Available. Registered Insurance Commission (ICWA) and WorkCover provider.
ILC Disability Equipment Grant (DEG) provider.

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DOTS REFERRAL

Date of Referral:_____

Referred for:
☐ Fitness to Drive
☐ Heavy Vehicle
☐ Vehicle modifications
☐ Driver Rehabilitation
☐ Return to Work/ Ergonomic Assess

Funding:
☐ Workcover/ Insurance
☐ ICWA
☐ Disability Equipment Grant
☐ JOBACCESS
☐ DVA
☐ Medicare EPC
☐ Private
☐ Pensioner

Client Details:
Surname:_____
Given Names: _____
Address: _____
_____
State: _____ P/code: _____
Telephone (H) _____
(M) _____
(W) _____
DOB: _____ Age: _____
☐ Male ☐ Female Interpreter required? Yes / No
Occupation: _____
NOK: _____
Relationship: _____ ☐ Contact NOK

Income: (please complete either individual or household for Grant purposes)
Individual: ☐ $0-$23000 ☐ $23000-$46000 ☐ >$46000
Household: ☐ $0-$35000 ☐ $35000-$75000 ☐ >$75000

Licence Details:
Licence no._____ Expiry date:_____
Current Vehicle:_____ (Auto / Man)
_____
Driving history Yes / No Years: _____
☐ First time driver _____
License Conditions _____
Date last driven _____

Referrer Details:
Referred by: _____
Provider no:_____(if applicable)
Company: _____
Address: _____
_____
State: _____ P/code: _____
Telephone: _____ Fax: _____
Email: _____

Medical History:
Date of Injury/ Illness (onset): _____
Diagnosis:_____
_____
_____
Past medical History: _____
_____
_____
Medications: _____
_____
_____
Impairments: _____
_____
_____
_____
_____
Insight: _____
Vision:_____
☐ *(Optometrist report attached)* ☐ *Glasses*
Current Treatment: _____
_____
_____

Treating Doctor: _____
☐ *General Practitioner* ☐ *Specialist:* _____
Address: _____
_____
State: _____ P/code: _____
Telephone: _____ Fax: _____

Medical Clearance for OT Assessment? Yes / No
M107a Form: ☐ Sent to Dept. ☐ Attached ☐ Client to bring
Please attach any further assessments/ relevant information

Account/ Employer: (Please complete for Insurance/ Workcover/ ICWA accounts)
Insurer: _____
Claim no. _____
Case manager _____
Address: _____
_____
State: _____ P/code: _____
Telephone: _____ Fax: _____
Email: _____

Employer: _____
Rehabilitation Coordinator: _____
Work address: _____
_____
State: _____ P/code: _____
Telephone: _____ Fax: _____
Email: _____

Signed: **Date:**

Please forward this referral to Driving Occupational Therapy Services - **Fax: (08) 9332 6548** or **Email: info@drivingotservices.com**
Once the referral is received the client will be contacted within one to three working days to discuss the assessment process and available subsidies