# Referral Form

## Occupational Therapy Driving Assessment

Brightwater
We see what others don't

### Client Details

Name:_____

Date of birth: _____

Address: _____

_____

Contact number: _____

Contact email:_____

Next of kin: _____

Contact number: _____

Diagnosis/ disability:_____

_____

Date of onset: _____

Other relevant medical history: _____

_____

Medications: _____

_____

Impairments which may impact on driving –

Physical and sensory: _____

_____

Vision: _____

Cognition: _____

_____

Mood and behaviour: _____

_____

Communication: _____

Client aware of the referral: Yes ☐ No ☐

### License Details (if known)

License number: _____

Expiry date: _____

Class: _____

Active: Yes ☐ No ☐ Unknown ☐

Current vehicle type: _____

Manual ☐ Automatic ☐

### Funding

NDIS ☐ ICWA ☐ Worker's Compensation ☐

HCP ☐ DVA ☐ Private ☐

### Referrer Details

Name: _____

Position: _____

Organisation: _____

Contact number: _____

Email: _____

Medical practitioner to sign below agreeing the client is medically fit to go on-road during the Occupational Therapy Driving Assessment

Medical Practitioner's Signature:

Name: _____

Date: _____

**Please send completed referrals to**
welcome@brightwatergroup.com
**Or phone 1300 223 968 for further information**