Brightwater
We see what others don't

Occupational Therapy Driving Assessment
Referral Form

Client Details

Name: ..... Date of birth: .....

Address: (Number) ..... (Street) .....
(Suburb) ..... (Postcode) .....
Contact Number: ..... Contact Email: .....

Primary Support Person: (Name) ..... Relationship to Client .....
Contact Number: ..... Contact Email: .....

Preferred First Contact Person when Booking an Appointment: ☐ Client ☐ Primary Support Person

Diagnosis / Disability: ..... Date of onset: .....
Other relevant medical history: .....

.....

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: ..... Contact 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: .....

Write your provider number or stamp here:

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