DriveAbility Rehab

ASSESSMENT REFERRAL FORM

CLIENT

NAME

ADDRESS

PHONE: MOBILE:

DATE OF BIRTH: DRIVERS LICENCE#: CONDITIONS:

OCCUPATION: DRIVERS LICENCE EXPIRY: CLASS:

☐ NDIS ☐ CTP ☐ WORKCOVER ☐ NON COMP ☐ PRIVATE CLAIM NO:

MEDICAL CONDTION

NATURE OF CONDITION/INJURY: INJURY/ONSET DATE:

NATURE OF SURGERY: SURGERY DATE:

☐ DOCTOR'S REFERRAL ATTACHED ☐ RMS FITNESS TO DRIVE FORM ATTACHED ☐ PREVIOUS OT DRIVER ASSESSMENT REPORT ATTACHED

NDIS

PARTICIPANT'S NDIS#: ☐ SELF-MANAGED ☐ NDIA MANAGED ☐ PLAN MANAGED

PLAN MANAGERS: EMAIL:

PHONE: FAX: CONTACT:

ADDRESS:

INSURER

INSURER:

POSTAL ADDRESS:

CLAIMS CONTACT:

PHONE: FAX: EMAIL:

REHAB CONTACT:

PHONE: FAX: EMAIL:

DOCTORS

TREATING DOCTOR: ADDRESS:

PHONE: FAX: EMAIL:

SPECIALIST: ADDRESS:

PHONE: FAX: EMAIL:

REQUIREMENTS

☐ OCCUPATIONAL THERAPY DRIVING ASSESSMENT

☐ OCCUPATIONAL THERAPY DRIVING RE-ASSESSMENT

☐ DRIVER TRAINING

☐ NDIS ASSISTIVE TECHNOLOGY ASSESSMENT

☐ OTHER

REFERRED BY: **DATE:**

COMMENTS

PLEASE EMAIL COMPLETED REFERRAL TO Cfrost@driveabilityrehab.com