Rehab Therapist Comprehensive Driving Evaluation Referral Form

Please fill out this form with as much information as possible and return via fax to our offices. This information is crucial for understanding if a client is ready to progress to a Behind-the-Wheel Evaluation. Please note, in order to initiate services, client will also need a Comprehensive Driving Evaluation Order Form filled out and signed by their referring provider with "Comprehensive Driving Evaluation and Treatment" selected. This form is available on our website under the "Providers" tab. If you have any questions or concerns, please feel free to contact us. Thank you!

Today's Date:_____

Rehab Therapist Name:_____ Practice Name:_____

Client Name:_____ DOB:_____Gender:_____

Address:_____ Phone Number: _____

Referring Physician Name: _____ Practice Name: _____

Phone: _____ Fax Number: _____

Will this physician be referring for the Comprehensive Driving Evaluation? ○**Yes** ○**No** ○**Unknown**

Primary Diagnosis: _____ Month/Year of Onset: _____

Relevant PMHx:

Is the client currently receiving therapy services? ○**Yes** ○**No**

History of Seizures? ○**Yes** ○**No** | Date of Onset: _____ Date of Last Seizure: _____

Recent coma and/or LOC? ○**Yes** ○**No** | Date of Onset: _____ Length of Coma: _____

History of Falls in the last 6 mo? ○**Yes** ○**No** | Number of Falls? _____

Pain? ○**Yes** ○**No** | Please describe:

Does client wear corrective lenses? ○**Yes** ○**No** | Describe: _____

Medical vision history: _____

Hearing: ○**Intact** ○**Impaired** | Does client wear hearing aids? ○**Yes** ○**No** | Comments:_____

Client consistently and accurately follows verbal instructions? ○**Yes** ○**No** | Comments:_____

Does client need alt. communication strategies? ○**Yes** ○**No** | Comments:_____

Please summarize client's recent rehab course (primary occupational/physical performance deficits, therapy goals, progression, discharge information etc.):

Occupational Profile (Starred* Measures Indicate Preferred Assessment Information)

Client lives: ○Alone ○With Spouse ○With adult child ○Other | Details: _____

Client's home is accessible for them: ○**Yes** ○**No** | Details: _____

Employment status: ○Full-time ○Part-time ○Retired ○On disability ○Unemployed ○Other_____

Formal ADL Measure & Score:
☐Barthel Index____ ☐AM-PAC*____ ☐AMPS_____ ☐GG Medicare Self-Care Items (A-I)*____ ☐Other_____

Is client independent (or modified independent) in the following IADLs?:
Meal Preparation: ○**Yes** ○**No** | Medication Management: ○**Yes** ○**No** | Financial Management: ○**Yes** ○**No**

Current ADL & IADL status details:

Is client currently driving? ○**Yes** ○**No** | Driving history details: _____

Additional occupational profile details: _____

Client Performance Factors (Starred* Measures Indicate Preferred Assessment Information)

<u>Vision & Perception:</u>
Distance Visual Acuity: Right:_____ Left:_____Both:_____

(Note: MT state minimum for driving without a restriction on a license is 20/40 in best eye.)

Extra-ocular muscles & ROM: ○**Intact** ○**Impaired**

Visual fields: ○**Intact** ○**Impaired** | Peripheral vision Right:____° Left:____° Inferior:____° Superior:____°

Convergence: ○**Intact** ○**Impaired** | Saccades: ○**Intact** ○**Impaired** | Pursuits: ○**Intact** ○**Impaired**

Vision Details: _____

Does client demonstrate deficits in visual-perceptual skills? ○**Yes** ○**No**

Perception Details: _____

<u>Cognition:</u>
Formal Cognition Measure & Score:
☐MOCA*_____ ☐BCAT*_____ ☐ MMSE____ ☐ SLUMS____ ☐ Allen Cog._____ ☐ Other_____

Attention: ○**Intact** ○**Impaired** | Dual-Task Attention: ○**Intact** ○**Impaired** | Memory: ○**Intact** ○**Impaired**

Cognition details:_____

Sensory-Motor Assessment:

Limb	ROM	Strength (MMT)	Sensation	Coordination	Comments
RUE	○ Intact ○ Impaired	/5	○ Intact ○ Impaired	○ Intact ○ Impaired	
LUE	○ Intact ○ Impaired	/5	○ Intact ○ Impaired	○ Intact ○ Impaired	
RLE	○ Intact ○ Impaired	/5	○ Intact ○ Impaired	○ Intact ○ Impaired	
LLE	○ Intact ○ Impaired	/5	○ Intact ○ Impaired	○ Intact ○ Impaired	

Cervical Range of Motion: ○ **Intact** ○ **Impaired** Details: _____

Functional Mobility Assessment:

Mobility device: ☐FWW ☐4WW ☐Cane ☐Walking stick(s) ☐Forearm crutch(es) ☐W/C ☐Other ☐N/A

Mobility status and device details:_____

Dynamic Sitting Balance: ○ **Intact** ○ **Impaired** | Functional Mobility Endurance: ○ **Intact** ○ **Impaired** ○ **N/A**

Can Client independently (or with set-up only) transfer into the driver's seat of a vehicle? ○ **Yes** ○ **No**

Formal Mobility Measure & Score:

☐Rapid Pace Walk*____sec ☐ 30 Second Chair Rise*____ reps ☐ TUG_____sec ☐Tinneti____ ☐Other:_____

Final Comments (if any):

Thank you for taking the time to fill out this form. We look forward to working with your client.

Referring Therapist Digital Signature (Full Name and Credentials)

Date of Signature

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