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| **OCCUPATIONAL THERAPY DRIVER EVALUATION REPORT** | | |
| Personal Information | | |
| Name: | | Date of Birth: |
| Address: | | |
| Phone Number: | Email: | |
| Licence Number | | |
| Conditions: | | |
| Source of Referral: | | |
| Diagnosis: | | |
| Medical History: | | |
| Off Road Assessment: | | |
| Make and Model of Vehicle Normally Driven: | | |
| Past / Present Driving Experience: | | |
| Relevant Medical / Psychiatric History: | | |
| Medication: | | |
| Vision Assessment: | | |
| Hearing: | Communication: | |
| Reaction Time: | | |

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| **UPPER LIMB FUNCTION** |

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|  | Left | Right | Functional implications for driving |
| Active Range of  Movement |  |  |  |
| Tone |  |  |  |
| Strength |  |  |  |
| Coordination |  |  |  |
| Pain Reported |  |  |  |
| Sensation |  |  |  |
| Endurance |  |  |  |
| **LOWER LIMB FUNCTION** | | | |
|  | Left | Right | Functional implications for driving |
| Active Range of  Movement |  |  |  |
| Tone |  |  |  |
| Strength |  |  |  |
| Coordination |  |  |  |
| Pain Reported |  |  |  |
| Sensation |  |  |  |
| Endurance |  |  |  |

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| Neck: |
| Trunk: |
| Sitting Balance: |
| Mobility: |
| Aids used: |
| Transfers: |
| Summary of / functional impact of physical function on driving: |
| Cognitive Function: |
| Attention: |

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| Concentration: |
| Perception: |
| Memory: |
| Planning: |
| Apraxia: |
| Thought Process: |
| Behaviour and Attitude: |
| Results of Road Law and Craft Knowledge |
| Road Law Test: |
| On Road Assessment Date: |
| Description: |

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| Characteristics: | |
| Non-Critical Actions: | |
| Critical Actions: | |
| **SUMMARY / RECOMMENDATIONS** | |
|  | |
| Therapist Name: | Date: |
| Designation: | |
| Signature: | |