



**REFERRAL FOR DRIVER ASSESSMENT & REHABILITATION**

**Note: all Occupational Therapy Driver & Rehabilitation Assessments are conducted in:**

Northern Districts Centre  
Unit 12, 8 Booth Place Balcatta  
(Entry via Erindale Road)  
Tel: 9240 5266 Fax: 9240 1522

To refer an individual for an Occupational Therapy Driver Assessment please fill in the following form as accurately as possible.

<p>Client name _____</p> <p>Date of birth _____</p> <p>Address _____</p> <p>Phone No. (H) _____</p> <p>(M) _____</p>	<p>Next of kin Name _____</p> <p>Phone No _____</p> <p>G.P _____</p> <p>Address _____</p> <p>Phone No. _____</p>
<p>Referring Agent: Name _____</p> <p>—</p> <p>Position _____</p> <p>Address _____</p> <p>Contact No. _____</p>	<p>Reason for referral</p>

Unit 12, 8 Booth Place  
Balcatta (via Erindale Road)  
Tel: 9240 5266 Fax: 9240 1522

Melville Aquatic Fitness Centre  
Marmion St, Booragoon  
Tel: 9364 8626 Fax: 9316 3904

Email: [appointments@pihc.com.au](mailto:appointments@pihc.com.au)  
Mailing Address: P.O Box 1574, Applecross, 6953  
ABN: 73 069 383 900  
ACN: 069 383 900



**CLIENT INFORMATION** (Indicate your response by ticking the relevant boxes)

Driving experience: _____ years	Current license Yes/No
Currently driving Yes/No	Licence/Permit No. Expiry date
Attitude to referral: positive <input type="checkbox"/> non committal <input type="checkbox"/> negative <input type="checkbox"/>	
Diagnosis and date of onset	Current medication: Compliant <input type="checkbox"/> Non compliant <input type="checkbox"/>
Vision impairment Yes/No	Hearing impairment Yes/No
Optometrist report attached <input type="checkbox"/>	Hearing aids Yes/No
Mobility	Communication

Thank you for completing all sections of this report.

Please attach copies of any assessments relevant to the impairments noted above and fax all to:  
**(08) 92401522 Attention: Occupational Therapist,  
Justine Zhong**

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_