Referral form

Drive on Therapy™

Please send completed referral form to **hello@driveontherapy.com.au** or phone (08) 6287 9115 for further information. This form can also be completed online via our website **driveontherapy.com.au**

Client details

Name: Date of birth:

Address:

Phone number: Email:

Primary contact

Name: Relationship to client:

Phone number: Email:

Preferred contact regarding appointment bookings: ○ Client ○ Primary contact

Client or primary contact is aware of referral: ○ Yes ○ No

Medical information

Primary diagnosis: Date of onset:

Other relevant medial history:

Purpose of referral:
○ Assess fitness to drive ○ Vehicle modifications for driving
○ Assess potential to learn to drive ○ Driver training
○ Vehicle modifications for passenger transport

Impairments that may impact driving

Physical and sensory:

Vision:

Cognition:

Mood and behaviour:

Communication:

Driving details

Licence number: Expiry date: Class:

Current vehicle transmission: ○ Automatic ○ Manual

Funding details

○ Private ○ NDIS ○ ICWA ○ HCP ○ Other:

Referrer details

Name: Position: Organisation:

Phone number: Email: