

Route 9W, West Haverstraw, NY 10993

Please complete the following checklist, giving special consideration to the effect of the participant's impairments on the driving task. If you have any other information (OT, PT or Psychological Assessment) that would be pertinent to our understanding of this participant, please attach it.

Participant name: _____ DOB: _____

Physician's (printed name): _____ Phys. Phone #: _____

Physician's address: _____ FAX #: _____

Primary Diagnosis: _____ Date of onset: _____

Secondary Diagnosis: _____

Past medical history: _____

Medical precautions: (cardiac, seizures) _____

Loss of consciousness or Coma: Onset: _____ Length of coma: _____

Seizure: Onset: _____ Date of last seizure: _____

Medications: _____

Communication: (significant receptive/expressive problems) _____

Vision: (acuity/visual fields) Intact Impaired Corrective Lenses Acuity: _____

Psychological/Cognitive Status: (learning disability, attention, memory, impaired judgement, processing skills)
 Intact Subtle Impairment Severe Impairment Comment: _____

Behavioral issues: none agitation emotional lability easily frustrated/angered resistant to feedback

Perception: (left or right neglect, visual-spatial) Intact Impaired Impaired, but compensates

Comments: _____

Musculoskeletal problems: (weakness, ataxia, abnormal tone, significantly limited range of motion)
Comments: _____

Mobility status: independent supervised assisted dependent // upright wheelchair

Transfer status into car: independent supervised assisted

Equipment: (assistive device, make/model of wheelchair, orthotics, prosthesis) _____

In your professional opinion, is this participant medically cleared to participate in driving assessment?
 Yes No Comments: _____

Physician's Signature: _____ Date: _____