HELEN HAYES
HOSPITAL
51-55 North Route 9W, West Haverstraw, NY 10993

Referral for Adaptive Driving Program

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 name (printed):_____ 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:_____