HELEN HAYES HOSPITAL

Helen Hayes Hospital, 51-55 N Route 9W, West Haverstraw, NY 10993

Driving Rehabilitation Program

Thank you for expressing interest in participating in the **Driving Rehabilitation Program** at Helen Hayes Hospital.

We're here to help individuals with various medical conditions begin, resume, or retain the ability to drive for as long as safely possible. Recommendations are individualized to the person's medical condition and the type of driving they desire to do. Our sensitive and experienced staff will assist you every step of the way.

The Driving Rehabilitation Program at Helen Hayes Hospital is staffed by trained, certified, and licensed Occupational Therapists who have specialized training in the area of driving. Our driving evaluations are comprehensive, assessing a variety of skills and factors that may affect a person's ability to drive.

Our driving evaluations include:

- Screening of vision, motor, and cognitive function related to fitness to drive.
- An on-road evaluation in our car which is equipped with a passenger-side brake for safety.
- Driving recommendations are provided to the patient and referring physician. The patient will follow up with their referring physician for final decisions related to driving recommendations.
- Driving rehabilitation/training services may include education, coordination of guided home programs to build driving skills, use of adaptive equipment, and/or in-car training with use of equipment or management with equipment while driving, all with a certified driving rehabilitation specialist.

This is a self-pay program; we will not bill your insurance. The cost for a driving evaluation is $300 and takes approximately 3 hours to complete.

For an on-road evaluation only, proof of a previous pre-driving assessment is required. The cost for an on-road evaluation only is $200.

Adapted driving training is available as needed.

To learn more about our Driving Rehabilitation Program, please call 845-786-4155.

To schedule a driving evaluation, the following forms included in this packet must be completed and returned:

1. A physician's referral
2. A valid driver's license or permit
3. A completed Driving Rehabilitation Program enrollment form

Please return completed forms to us via mail, email, or fax:

Helen Hayes Hospital
51-55 North Route 9W
West Haverstraw, NY 10993
Att: Lynn Matthes, Outpatient Occupational Therapy

Fax: 845-786-4963, Attention: Lynn Matthes, Outpatient Occupational Therapy

Email: lynn.matthes@helenhayeshosp.org

Driving Rehabilitation Program Enrollment Form

Please read, complete, and sign this Driving Rehabilitation Program enrollment form. It will provide key information for us to determine your needs

Name:_____ Date of Birth/Age_____

Address:_____

Phone:_____ Cell Phone:_____

Emergency Contact:_____ Relationship:_____ Phone:_____

Driving Questionnaire

1. What is your reason for requesting a driving evaluation?_____
   _____
2. Do you have a current driver's license? Yes____ No____ State:_____
3. When was the last time you drove?_____
4. What type of car do you drive? SUV/Truck____ Sedan____ Standard____ Automatic____
5. When you last drove or if you are currently driving, what kind of driving do you do? Local roads____ Highways____ City____ Nighttime____ Inclement weather____
6. Have you ever gotten lost while driving?_____
7. Have you had any accidents in the past year or near misses/unexplained dents scratches on vehicle? Yes____ No____
   If yes, please explain_____
8. Do you need any help getting into or out of a car? Yes____ No____
9. Have you had any falls in the past year? Yes____ No____ If yes, how many?_____
10. Are you experiencing any difficulty moving an arm or leg? Yes____ No ____
    If yes, please explain_____
11. Please list any equipment you use for mobility including: wheelchair (make/model/year), walker, cane, braces, etc:_____
    _____
12. Are you experiencing decreased sensation/sensory changes in your legs? Yes____ No____
    If yes, please explain_____
13. Are you experiencing any difficulty turning your head? Yes____ No____ If yes, please explain_____
14. Are you experiencing any difficulty with your concentration or memory? Yes____ No ____
    If yes, please explain_____
15. Do you feel your reactions are quick enough to handle dangerous driving conditions? Yes____ No ____
16. Do you wear glasses when you drive? Yes____ No ____
17. When was your last eye exam?_____
18. Do you have any pending eye surgeries?_____
19. Are you experiencing any difficulty with your vision? Yes____ No ____
    If yes, please explain_____

20. In the past year have you experienced any episodes of blackouts, fainting spells, loss of consciousness, or seizures? Yes ___ No ___
    If yes, please explain _____
21. Are you experiencing any pain? Yes___ No___
    If yes, indicate the location:_____
22. In the past has a friend or family member expressed any concerns about your driving? Yes___ No___
    If yes, please explain _____
23. Do you need help with any of the following? getting dressed___ taking medications___ following medication schedule___ paying bills___
24. Please list all current medications:_____
    _____
    _____
25. Have you ever been a patient at Helen Hayes Hospital? Yes___ No___
    If yes, do you give permission for the Adapted Driving staff to access your Medical records? Yes___ No___

1. I have fully discussed my participation in the Driving Rehabilitation Program with my doctor and my doctor has agreed that I am appropriate for such a program.
2. I have accurately and honestly answered all the questions on this enrollment form.
3. I understand that I should not drive myself to the evaluation.
4. I understand that completion of the Driving Rehabilitation Program does not guarantee that I will be safe to drive.
5. I understand that a copy of my evaluation results will be sent to my physician.
6. I give permission for DMV to be contacted to verify that my license is currently valid.

_____ _____
PARTICIPANT SIGNATURE DATE

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

Referral for Driving Rehabilitation 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:_____