HammondCare
An independent Christian charity

DRIVER ASSESSMENT AND TRAINING SERVICE REFERRAL

CLIENT INFORMATION **Date of Referral:** _____/_____/____

Name: _____Date of Birth:_____/_____/____ Sex: ☐ M ☐ F

Address: _____Suburb:_____ Postcode: _____

Occupation: _____ Phone: _____M: _____

OTHER CONTACTS:

Family/Carer: _____ Contact Number: _____

General Practitioner: _____ Contact Number: _____

REFERRAL DETAILS:

Diagnosis/ Reason for Referral: _____

_____

Date of Onset/ Other Relevant Medical Conditions/ History: _____

_____

_____

Medications (include dosage): _____

_____

IMPAIREMENT DETAILS:

Vision: _____ Motor: _____

Sensation: _____ Perception: _____

Cognition: _____ Behavior: _____

Communication: _____ Interpreter Required: ☐ Yes ☐ No

Medical Clearance to Drive ☐ Yes ☐ No Sent to RTA ☐ Yes ☐ No

Attached ☐Yes ☐ No Client to Bring to Ax

LICENCE DETAILS:

Current Licence ☐ Yes ☐ No Sent to RTA ☐ Yes ☐ No

Class: _____ Last Driven: _____/_____/_____

REFERRING DETAILS:

Name: _____ Sign:_____

Place of Work/Position: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

PLEASE ENSURE THE CLIENT IS AWARE OF THIS REFERRAL AND THAT FEES ARE CHARGED

Please Return Completed Form to:

HammondCare
Greenwich Hospital
Occupational Therapy
Driver Assessment and Training Service
97-115 River Road, Greenwich, NSW 2065
Ph P: (02) 9903 8337 F: (02) 9903 8245