# Community Accessible Rehabilitation (CAR) Pre-Driving Assessment Referral

Phone 403.943.0279

**Fax the completed form to 403.943.0578**

**Incomplete or unreadable referrals will be returned**

| Last Name | First Name |
|---|---|
| PHN / HRN | |
| Address | |
| Phone | Date of Birth *(yyyy-Mon-dd)* |

**Refer to the Alberta Directory for eligibility criteria**

**Date of Referral** *(yyyy-Mon-dd)*

## Referral Information

| Diagnosis | Date of diagnosis / injury / event |
|---|---|
| | |

Areas of impairment that may impact driving *(check all that apply)*

☐ Motor impairment
  ☐ U/E
  ☐ L/E
☐ Perceptual Impairment
☐ Visual impairment *(specify)* ____________________________

☐ Cognitive impairment *(specify and attach cognitive screen/report)*
______________________________________
______________________________________
☐ Endurance/ Fatigue issues
☐ Other ________________________________

Is the client's medical condition stable? ☐ Yes ☐ No

Does the client meet the medical standards for driving in Alberta *(including stable seizures/medication for seizures)*?
☐ Yes ☐ No

Does the client have a valid driver's license? ☐ Yes ☐ No
If no, why not? __________________________________________________________

Based on vision assessment by physician or optometry *(including visual fields and acuity)*, *(check all that apply)*
☐ No noted visual concerns that impact safe driving
☐ Client meets vision standards for driving in Alberta
☐ Client does not meet vision standards for driving in Alberta and has been directed to have a Pre-Driving Assessment by Alberta Transportation *(attach this documentation)*
☐ Client has a visual field cut/impairment and
  ☐ Requires treatment for the visual field cut
  ☐ Has learned to compensate for the visual field cut

Are there any psycho-social issues that may impact return to driving? ☐ Yes ☐ No
If yes, specify: __________________________________________________________

Is the client taking any medication that may impact the ability to drive safely? ☐ Yes ☐ No
If yes, specify: __________________________________________________________

## Required Documents

☐ Copy of the completed Medical Examination for Motor Vehicle Operators form that was faxed to Alberta Transportation
☐ Relevant medical consults or rehabilitation discharge summaries
☐ For clients with vision impairment: copy of the Alberta Transportation Visual Referral Report
☐ For clients with visual field deficits: Humphrey's or Goldman test results

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| **Additional Information** | | |
|---|---|---|
| Does the client require to drive to return to work? ☐ Yes ☐ No | | |
| Was the client previously tested for return to driving? ☐ Yes ☐ No<br>If yes, when and where? ______________________________ | | |
| Did the client complete all necessary rehabilitation and/or medical treatments and is ready for a Pre-driving assessment? ☐ Yes ☐ No | | |
| For clients under the age of 18 years: does the guardian support the pre-driving assessment? ☐ Yes ☐ No | | |
| ☐ Language or communication barrier,<br>* Requires interpreter, Language ______________<br>* Communication barrier ______________ | | ☐ Client will attend appointments with a support person |
| **Alternate contact for booking appointments** *(if applicable)* | Name | |
| Phone | Email | Relationship |

| **Physician Information** | | |
|---|---|---|
| Name | Fax | Phone |
| Signature | | Date *(yyyy-Mon-dd)* |