

**DRIVING AND HEALTH CLINIC
SPECIALIST DRIVING ASSESSMENT REFERRAL FORM**



Dr Lydia Huang, Dr Kirrily Holton, Dr Adrian Winsor: Rehabilitation Physicians
Nicki Hayball: Occupational Therapist Driver Assessor

Client Details:

Surname: _____ Given Name: _____
DOB: _____ Gender: Male Female
Address: _____
_____ Post Code: _____
Home Phone: _____ Mobile: _____
Private Health Insurance Fund: _____
Member No: _____
DVA Card No: _____
Contact Details: *(If different from Client)*
Contact Person: _____ Relationship: _____
Phone No: _____

Reason for Referral:

Priority: Urgent 2-4 weeks Non Urgent

Medical History / Medications:

Referring Doctor Details:

Name: _____ Provider No: _____
Address: _____
_____ Post Code: _____
Phone No: _____ Fax No: _____
Signature: _____ Date: _____

General Practitioner Details: *(If different from Referring Doctor)*

Name: _____ Provider No: _____
Address: _____
_____ Post Code: _____
Phone No: _____ Fax No: _____

Please print this form when completed and fax: to (08) 8298 5520