

**Driving Rehabilitation Program**

**Patient Name:** \_\_\_\_\_

**Pre-Driving Evaluation**

**Date:** \_\_\_\_\_

Age \_\_\_\_ License/ Permit \_\_\_\_\_ EXP Date: \_\_\_\_\_ Restrictions \_\_\_\_\_

Previous Driving Experience: \_\_\_\_\_ Dominance: R L Seizures: Yes or No

Diagnosis \_\_\_\_\_ Onset Date: \_\_\_\_\_

Medications: \_\_\_\_\_

**Physical Considerations**

Neck ROM \_\_\_\_\_

Upper Extremities \_\_\_\_\_

Lower Extremities \_\_\_\_\_

Transfer Status \_\_\_\_\_

W/C Loading \_\_\_\_\_

Reaction Time: RLE \_\_\_\_\_ LLE \_\_\_\_\_ RUE \_\_\_\_\_

Equipment: \_\_\_\_\_

**Vision**

Glasses: Yes or No Acuity: (MIN. STD. @ 20/50) Left \_\_\_\_\_ Right \_\_\_\_\_ Both \_\_\_\_\_

Fields Intact Impaired \_\_\_\_\_

Depth Perception Intact Impaired \_\_\_\_\_

Saccades Intact Impaired \_\_\_\_\_

Pursuits Intact Impaired \_\_\_\_\_

Vision Waiver Issued? YES or NO

**Perceptual/ Cognitive Tests**

	Pass AVG	Score	Pass AVG	Below AVG
Trail making Part A				
Trail making Part B				
Clock Drawing Test				
Visual Form Discrimination				
Short Blessed Test				

**Behaviors**

Evaluation  Inattention  Impulsivity  Distractibility  Anxiety  Confusion  Slowness  Directions

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Summary and Recommendations:**

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