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| Medical Fitness to Drive Assessment – Referral | | | | | |
| The Laura Fergusson Assessment team provides a private Medical fitness to drive assessment service across the South Island. Ask your GP or other registered health professional to complete this form for a self-funded medical fitness to drive assessment. | | | | | |
| Patient/Client Details | | | | | |
| **Name** |  | | | | **DOB** |
| **Address** |  | | | | **NHI** |
| **Home Phone** |  | **Mobile** | | | **Ethnicity** |
| **Email** |  | | | | |
| **Next of Kin** |  | | | | |
| **Phone** |  | | **Email** |  | |

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| --- | --- | --- | --- |
| Reason for Referral | | | |
| Specific concern regarding a medical condition and any impact on Driving | | | |
| Age related medical driving assessment to support GP endorsement of retaining licence | | | |
| Second opinion of previously failed assessment | | | |
| Other | | | |
| **Please Confirm** | | | |
| Clients visual acuity meets required standard  Yes  No | | | |
| **Visual Acuity Score** |  | ***Provide documentation from Eye Specialist*** | |
| Status of driver licence  Current  Expired  Revoked  Suspended  Other (see below) | | | |
| Additional Details: | | | |
| **MOCA/Mini ACE Score** |  | **Date Taken** | Select date |

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| --- | --- |
| Referral Source (Mandatory) | |
| **Name of Referrer** |  |
| **Organisation/Relationship to Client** |  |
| **Address** |  |
| **Phone Number** |  |
| **Email** |  |

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| Medical History (Mandatory) or *attach relevant injury/medical information* |
|  |
| **List of Medications or *attach relevant injury/medical information*** |
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| Send Referral to |
| Laura Fergusson Assessment Team - Email hello@lfbit.co.nz  or phone 03 335 0541 for further information |