DRIVER ASSESSMENT SCREEN

FOR MEDICAL PROFESSIONALS

Name: _____ DOB: _____

MD Name: _____ Date: _____

01. Past Medical History ☐ CP ☐ OCD ☐ Seizures ☐ Intellectual Disability Other: _____
☐ Autism ☐ Spina Bifida ☐ Anxiety ☐ ADD/ADHD _____

02. History of Falls? ☐ Yes ☐ No Device for Ambulation? ☐ Yes ☐ No

03. Vision Considerations:

Glasses: ☐ Yes ☐ No

Eye doctor visit within the last year? ☐ Yes ☐ No

Please check off if the patient has been diagnosed with any of the following:

☐ Juvenile Macular Degeneration ☐ Amblyopia ☐ Strabismus ☐ Double Vision

04. Has the patient been involved in sports, riding a bicycle, or driving a go kart? ☐ Yes ☐ No

Comments: _____

05. Does the patient independently perform ADL's? ☐ Yes ☐ No

06. Does the patient participate in shopping, cooking, cleaning, and cooking at home?

☐ Yes ☐ No ☐ With Prompting ☐ Without Prompting

Comments: _____

07. Has the patient or a family member voiced concerns with the patient obtaining a permit and/or difficulty with passing a permit test or road test? ☐ Yes ☐ No

08. Has the patient had any difficulty with coping skills or behavioral issues at home or in school? ☐ Yes ☐ No

YES to at least 2 questions and the patient has medical condition that could affect their safety behind the wheel, a driver assessment is recommended