DRIVING SOLUTIONS

Helping you make the right decision

Dear _____,

Thank you for your interest in the Driving Solutions, LLC driver evaluation program. Enclosed is information pertaining to program requirements. Driver evaluation is ideally an open process, one that involves extended family, clear communication and objective measures.

The program serves drivers of all ages with any question that needs to be answered about safe driving. We help you make the right decision.

This service is professional, comprehensive, individualized and based on the best practices of the American Medical Association, the Association for Driver Rehabilitation Specialists, the American Occupational Therapy Association and the Commonwealth of Massachusetts, Registry of Motor Vehicles, Medical Affairs Board.

To begin the evaluation process you will need the following:

- MD order for "OT Driver Evaluation"
- Completed medical history questionnaire
- List of medications taken
- A copy of your current driver's license or permit
- Completed Driver Profile questionnaire, 2-sided, with contact information.
- Payment is required at the time of service and is $325. for the clinical evaluation.

A formal written report to the driver and the MD is provided, following the evaluation

What is unique about this service is that we travel to you, understanding that people with driving issues are sometimes overwhelmed with appointments and hampered by transportation.

Driver evaluation is the simplest way to comply with Massachusetts laws regarding self-reporting of medical conditions. You will avoid RMV waiting periods and comply with self reporting law at the same time.

If you have questions about the evaluation process or are ready to reserve an evaluation appointment, please contact us.

Judy M. Romano, MS, OTR/L
Occupational Therapist
Driver Evaluation Specialist
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508 878 9583

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Medical History Questionnaire

Do you have, or have had, any of the following in the last five years? Please circle or underline all that apply and gather the documents listed at the bottom of this page.

Diabetes or other metabolic condition , High blood pressure, use of insulin, fainting , loss of consciousness, Low blood sugar, Syncope, Thyroid condition

Cardiovascular: Heart attack, Heart blockage, Heart surgery, Irregular rhythm, Pacemaker, use of statin drugs, falls.

Pulmonary: Lung condition, Asthma, Emphysema, Obstructive pulmonary condition, Shortness of breath, use of inhaler.

Neurologic: Stroke, Epilepsy, Seizure, Multiple sclerosis, ALS, Parkinson's Disease
Brain injury, peripheral neuropathy, concussion, car crash with personal injury or property damage.

Narcolepsy. Have you ever fallen asleep while driving?

Epilepsy: Seizure, other episodic conditions that include any recurrent loss of consciousness or control ? Have you ever had a seizure in your life?

Learning and Memory: Learning disability, short term memory loss reported by others, difficulty in handwriting or completing school , job or home management tasks.
ADD or ADHD sleep apnea treated with medication. Aspberger's, PDD or autism.

Psychiatric: Condition of anxiety, stress, depression, bipolar disorder, schizophrenia for which you take medication or have received counseling or hospitalization.

Alcohol and/or Drugs: Dependency or abuse of substances that are known to impair thinking and judgment. Any detox or treatment programs for alcohol or drug dependency. Do you take several prescription medications on a daily basis?

Visual Problems: Need for reading glasses, need for distance glasses/contact lenses, glaucoma, cataracts, macular degeneration, retinopathy, iritis, legal blindness, loss of vision in part of the visual field, diminished side vision. Do you use daily eye drops?

Musculosketletal conditions: Amputation or paralysis of a limb. Arthritis of the neck, spine, low back, knees, ankles, feet, hips. Osteoporosis or congenital abnormalities. Unusually short/long limbs. Any chronic infection or virus that could endanger someone coming in close contact with you? Do you use prescription pain relievers?

Functional Motor Impairment: Use of a brace, prosthesis, splint, cast, cane or support for any body part. Any problem identified with coordination, muscle strength, range of motion or spinal movement that could affect your ability to safely drive. Have you had any falls? How many_____

Other: Any other condition or medication that might interfere with safe driving? _____

Collect the following documents:

1. Signed MD order for OT Driver Evaluation
2. List of medications you currently take
3. Photocopy of your driver's license or learner's permit

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Contact Sheet and Driver Profile

Name_____ Address_____

License #_____ State: Massachusetts / Other _____

Driving Restrictions_____ License Status: Active / Suspended / Revoked / Expired

License Expiration Date _____ Current Age/Date of Birth _____

I have_____ years of driving experience. My driving record is: fair/ good/ very good/ flawless.

Describe your driving history: _____

List any incidents/ tickets _____

Reason for evaluation_____

1. I currently drive on a daily /weekly /occasional basis_____
2. I last drove on _____
3. I sometimes/always use glasses for driving_____
4. I average_____ miles of driving per/ day / month / year
5. My destinations are rarely /sometimes/ often/ usually within the local area.
6. Usually I do /do not drive alone_____
7. Driving a vehicle is an essential non-essential part of my day's work_____
8. I commute between home and _____on a regular basis
9. I rarely/sometimes/ often/ usually drive to out-of-state locations _____
10. I rarely/sometimes/ often/usually drive in city areas
11. Side mirrors are helpful/essential/ for backing up and changing lanes
12. I do/ do not drive very slowly and carefully _____
13. I stay off the roads in poor weather rarely/sometimes/ often/usually
14. I find ways to avoid parallel parking _____
15. Changing lanes on the highway is difficult_____
16. I sometimes/frequently/usually stop before merging onto a rotary or highway
17. Cars to the right sometimes/ frequently/ usually have the right of way
18. I do/ do not try to keep pace with fast traffic
19. Traffic rules do / do not apply in parking lots_____
20. A traffic sign with red on it generally means_____

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21. I sometimes / frequently / usually rely on my passengers to help me when I drive
22. Cars in a rotary sometimes/frequently/usually have the right of way
23. When driving, it's best to keep my eyes on the car directly in front of me_____
24. Glare, even if not direct, bothers my eyes_____
25. Getting in and out of my driveway is difficult/easy/other
26. Getting lost in a familiar area is not a big deal_____
27. As long as I drive slowly, I am okay on the road
28. Driving behind or beside a truck is _____
29. Due to my size I have trouble seeing over the wheel, reaching the pedals_____
30. When an emergency vehicle is approaching, I must_____
31. If unsure where to go, I stop and look around / pull over to the side
32. In Mass. drivers are sometimes/ frequently/ usually able to take a right on red
33. Communicating with other drivers is simple/ difficult / impossible/risky
34. A clean windshield makes a difference in how well I see at night _____
35. All yellow signs basically mean _____
36. When you see a yellow light it's sometimes/usually OK to go through it
37. A blinking red light means _____
38. Another word for YIELD is_____
39. In Massachusetts pedestrians sometimes/ frequently/usually have the right of way
40. There are eye conditions that make it more difficult to drive
41. Massachusetts has specific laws regarding older drivers _____
42. Massachusetts has specific laws regarding teen drivers _____
43. Massachusetts has specific laws regarding impaired drivers_____
44. Massachusetts is a self reporting state meaning each driver is responsible for their own safety and ability behind the wheel _____

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Client Name: _____

Address: _____

Telephone Number: _____

Diagnosis/Reason for Evaluation: _____

_____

Current Medications: _____

_____

Please check all that apply:

_____ Seizure/loss of consciousness
_____ Implanted cardiac defibrillator
_____ Syncope
_____ O2 sat level 88% or less at rest or with minimal exertion
_____ FEV-1 level of 1-2 liters or less
_____ Arthritis condition which renders the individual unable to perform self care
_____ Alcohol/substance abuse
_____ Behavioral issue/learning issue
_____ Visual issues
_____ Motor vehicle accident
_____ License suspension/revocation
_____ Cognitive issue
_____ Medical clearance following change in health status

Referring Physician: _____

Physician Address: _____

Telephone Number: _____

Physician Signature: _____

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