

Referral Form Driving Assessment & Training

		Date of referral				
Client details				Contact for a	appointment	:s
Name						
Address						
Email			Gender			
Phone			Different	e Female identity (please	genuen	ary/ luid
Date of birth						
Interpreter required	Yes No	Language/cultural back	kground e.g. Al	SI		
Licence no.			Expiry			
License type	Manual Auto	RMS fitness to c	drive medica	l report attac	hed (require	d)
Next of kin deta	ils			Contact for	appointmen	ts
Name						
Address						
Email			Phone			
GP details						
Name						
Clinic name			Phone			
Address						



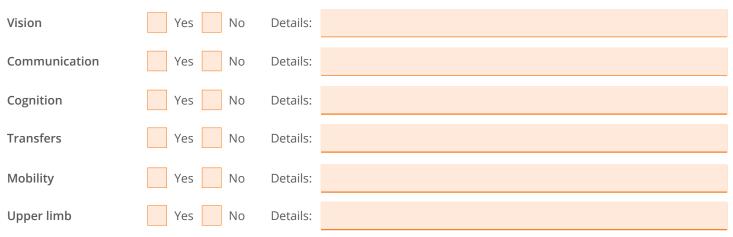
Referrer details (if not doctor)

Name						
Organisation		Phone				
Address						
Reason for refer Initial Assessment Other (please specify):	ral Reassessment Lessons					
Funding details						
Participant number (if relevant):		Self-funding NDIS icare Other funding (please specify):				
Approval attached	or, quote required	Other funding (please specify).				
IF NDIA						
NDIA (agency managed) Self managed Plan managed						
Plan Manager name:						
Email		Phone				
If icare/compensable						
Name						
Address						
Email		Phone				
CRN/Pension no.		Medicare no.				
Pension	Disability Aged					
(Other (please specify):					



Primary disability / Impairment / Relevant health information:

Current Functional Issues (if applicable)



If required, please take your medical fitness to drive report to Service NSW (RMS/RTA) to obtain a temporary licence. Please keep a copy of the medical fitness to drive and return with this referral form to driving@royalrehab.com.au, fax to (02)80884783 or post to :- PO Box 6, RYDE NSW 1680