Functional Driver Evaluation

CLAIM NUMBER	RECOVERY SPECIALIST	DATE OF CRASH (dd/mmm/yyyy)
RECOVERY SPECIALIST EMAIL		RECOVERY SPECIALIST PHONE NUMBER

CUSTOMER INFORMATION

FIRST NAME		LAST NAME
DATE OF BIRTH (dd/mmm/yyyy)	PHONE NUMBER	EMAIL
ADDRESS		
ADDRESS		
CLIENT DRIVER'S LICENCE(S)		CLASS(ES)
RESTRICTIONS ON DRIVER'S LICENCE ☐ Yes ☐ No If yes, please include date and license restrictions, if known		
ASSESSMENT DATE (dd/mmm/yyyy)		ASSESSMENT DATE 2 (if applicable) (dd/mmm/yyyy)
ASSESSMENT CONDUCTED BY		

Reason for Referral (including referral source, symptom onset timeline *if known*, stage of recovery *if known*)

Relevant medical and rehabilitation information (Including documents reviewed, medications if applicable)

Relevant pre-crash medical history

Driving Profile

HAS CLIENT PREVIOUSLY COMPLETED A DRIVING ASSESSMENT RELATED TO CURRENT RELEVANT ACCIDENT? Yes ☐ No ☐
If yes, please include date and outcome:

HAS THE CLIENT REPORTED TO YOU THAT THEY HAVE ATTEMPTED TO DRIVE POST CRASH? Yes ☐ No ☐
If yes, describe their reported current status with driving:

WHEN DID CLIENT REPORT THEY LAST DROVE INDEPENDENTLY?

DRIVING EXPERIENCE (Number of years, vehicle type)

REPORTED PRE-ACCIDENT DRIVING FREQUENCY
- ☐ Daily
- ☐ Weekly
- ☐ Episodic
- ☐ Not applicable (not a driver)

REPORTED CURRENT METHOD(S) OF TRANSPORTATION (please select all that apply)
- ☐ Driving but restricted/not at pre-crash level
- ☐ Passenger
- ☐ Taxi/Ride Sharing
- ☐ Public Transportation: Bus/train/Handy DART
- ☐ Other: _____

TYPES OF VEHICLES PREVIOUSLY DRIVEN
- ☐ Automatic
- ☐ Manual
- ☐ Other: _____

CUSTOMERS DRIVING GOALS

Physical assessment

Skill Tested: **Tone/coordination** ☐ Functional ☐ Skill Deficit ☐ Not tested

OBJECTIVE FINDINGS

Skill Tested: **Strength/ROM — Neck/Trunk** ☐ Functional ☐ Skill Deficit ☐ Not tested

OBJECTIVE FINDINGS

Skill Tested: **Strength/ROM — Upper Extremities** ☐ Functional ☐ Skill Deficit ☐ Not tested

OBJECTIVE FINDINGS

Skill Tested: **Strength/ROM — Lower Extremities**	☐ Functional ☐ Skill Deficit ☐ Not tested
OBJECTIVE FINDINGS	

Skill Tested: **Grip Strength**	☐ Functional ☐ Skill Deficit ☐ Not tested
OBJECTIVE FINDINGS	

Skill Tested: **Sensation/Proprioception — Upper Extremities**	☐ Functional ☐ Skill Deficit ☐ Not tested
OBJECTIVE FINDINGS	

Skill Tested: **Sensation/Proprioception – Lower Extremities**	☐ Functional ☐ Skill Deficit ☐ Not tested
OBJECTIVE FINDINGS	

TOLERANCE(S) OBSERVED
1.
2.
3.
4.
5.

Skill Tested: **Sitting Balance**	☐ Functional ☐ Skill Deficit ☐ Not tested
OBJECTIVE FINDINGS	

Skill Tested: **Ability to get in and out of car independently**	☐ Functional ☐ Skill Deficit ☐ Not tested
OBJECTIVE FINDINGS	

Skill Tested: **Other:**	☐ Functional ☐ Skill Deficit ☐ Not tested
OBJECTIVE FINDINGS	

Skill Tested: **Other:**	☐ Functional ☐ Skill Deficit ☐ Not tested
OBJECTIVE FINDINGS	

Skill Tested: **Other:**	☐ Functional ☐ Skill Deficit ☐ Not tested
OBJECTIVE FINDINGS	

Skill Tested: **Other:**	☐ Functional ☐ Skill Deficit ☐ Not tested
OBJECTIVE FINDINGS	

Skill Tested: **Other:**	☐ Functional ☐ Skill Deficit ☐ Not tested
OBJECTIVE FINDINGS	

Cognition

Skill Tested: **Attention/Psychomotor speed**	TEST USED	☐ Functional ☐ Skill Deficit ☐ Not tested
OBJECTIVE FINDINGS		

Skill Tested: **Response time index**	TEST USED	☐ Functional ☐ Skill Deficit ☐ Not tested
OBJECTIVE FINDINGS		

Skill Tested: **Metacognition**	TEST USED	☐ Functional ☐ Skill Deficit ☐ Not tested
OBJECTIVE FINDINGS		

Skill Tested: **Other:**	TEST USED	☐ Functional ☐ Skill Deficit ☐ Not tested
OBJECTIVE FINDINGS		

Skill Tested: **Other:**	TEST USED	☐ Functional ☐ Skill Deficit ☐ Not tested
OBJECTIVE FINDINGS		

Skill Tested: **Other:**	TEST USED	☐ Functional ☐ Skill Deficit ☐ Not tested
OBJECTIVE FINDINGS		

Vision

Skill Tested: **Acuity**	TEST USED	☐ Functional ☐ Skill Deficit ☐ Not tested
OBJECTIVE FINDINGS		

Skill Tested: **Peripheral**	TEST USED	☐ Functional ☐ Skill Deficit ☐ Not tested
OBJECTIVE FINDINGS		

Skill Tested: **Dynamic Scan**	TEST USED	☐ Functional ☐ Skill Deficit ☐ Not tested
OBJECTIVE FINDINGS		

Skill Tested: **Other:**	TEST USED	☐ Functional ☐ Skill Deficit ☐ Not tested
OBJECTIVE FINDINGS		

Skill Tested: **Other:**	TEST USED	☐ Functional ☐ Skill Deficit ☐ Not tested
OBJECTIVE FINDINGS		

Skill Tested: **Other:**	TEST USED	☐ Functional ☐ Skill Deficit ☐ Not tested
OBJECTIVE FINDINGS		

Is the client currently seeing an Optometrist or Ophthalmologist to address these driving related challenges?

☐ Yes ☐ No ☐ Unknown

Additional Comments

Behaviour/Psychosocial

Skill Tested: **Impulsivity/Initiation**	☐ Functional ☐ Skill Deficit ☐ Not tested

OBJECTIVE FINDINGS

Skill Tested: **Aggression/Anger**	☐ Functional ☐ Skill Deficit ☐ Not tested

OBJECTIVE FINDINGS

Skill Tested: **Anxiety**	☐ Functional ☐ Skill Deficit ☐ Not tested

OBJECTIVE FINDINGS

Skill Tested: **Other:**	☐ Functional ☐ Skill Deficit ☐ Not tested

OBJECTIVE FINDINGS

Skill Tested: **Other:**	☐ Functional ☐ Skill Deficit ☐ Not tested

OBJECTIVE FINDINGS

Skill Tested: **Other:**	☐ Functional ☐ Skill Deficit ☐ Not tested

OBJECTIVE FINDINGS

What does the client do to manage their skill deficits above as they relate to driving?

Is the client currently seeing a psychiatrist, psychologist, or counsellor to address these driving related challenges?

☐ Yes ☐ No ☐ Unknown

Additional Comments *(Further observations during assessment, collateral family/friend reports, substance use or aggressive behaviors that have an impact on driving may be indicated here)*

On Road Evaluation for License ☐ Class 5 ☐ Class 7N ☐ Class 7L ☐ Other (Specify): _____

Adaptive Driving Equipment trialled? ☐ Yes ☐ No If yes, please list below

On-Road Test Date (ddmmmyyyy) Date 2 (if applicable) (ddmmmyyyy)

Summary

Recommendations (select one)

☐ No Significant impairments identified impacting functional ability to drive

☐ Impairments were identified impacting functional ability to drive. Recommend Driving Rehabilitation with no vehicle adaptations.
If yes, please complete Driver Rehabilitation Recommendation table below.

Additional comments:

☐ Impairments were identified impacting functional ability to drive. Recommend Driving Rehabilitation with vehicle adaptations. Please complete Driver Rehabilitation Recommendation table below and
- For low tech, please provide detail below, with quote if known.
- For high tech adaptations, please confirm with Claims Contact if additional adaptation/acquisition form is required.

☐ Impairments were identified impacting functional ability to drive and driver rehabilitation, vehicle modifications or vehicle acquisition are not expected to be of benefit at this time.

Driver Rehabilitation Recommendation (If applicable)	
START OF PROGRAM (ddmmmyyyy)	END OF PROGRAM (ddmmmyyyy)

OT Professional Services	_____ hours

	Number of sessions	Cost per session	Tax (if applicable)	Cost
Driving School Services				
Other (enter additional services)				
Other (enter additional services)				
Other (enter additional services)				
Other (enter additional services)				
			Total Cost	**$0.00**

Additional Information (Please include any relevant information not captured above)

This form must be completed in full. Incomplete reports may result in delays or impact treatment funding approval.

☐ I certify that the information provided is true and correct to the best of my knowledge.

Providing false or misleading information may result in the cancellation of your vendor number, and ICBC may seek financial restitution and/or take legal action.

Personal information on this form is being collected under section 26 of the *Freedom of Information and Protection of Privacy Act (BC)* and section 28 or 28.1 of the *Insurance Vehicle Act (BC)* for the purpose of obtaining a health care report in order to manage the claim. Questions about the collection of this information may be directed to the claim representative, or call 604-661-2800 or contact the Privacy & Freedom of Information department at 151 Esplanade, North Vancouver, BC V7M 3H9.