

UKHDI Driver Rehabilitation Application

Please fill completely with all relevant information

Name: _____ **Date:** _____

Home Phone: _____ **Cell Phone** _____

Alt. Contact _____ **Phone** _____

Address DOB: _____

Email: _____ **Permit /License:** _____

Gender: _____

_____ **Height:** _____ **Weight:** _____

1. What is your Medical Condition/Diagnosis? _____
A) If Spinal Cord Injury, what level? _____ When was this diagnosis made? _____
B) Incomplete? ___Yes ___ No
2. Are you currently being treated for this medical condition? ___Yes ___ No; Please list any medications you are currently taking. _____

3. Have you had a seizure in the last 6 months? ___Yes ___ No; If yes, date of seizure _____
4. Do you have a current driver's license or learner's permit that allows you to be evaluated on public streets? ___Yes ___ No; If not, has your license been suspended/revoked or turned into the Medical Review Board? ___Yes ___ No.
We are not able to schedule an appointment until a license or permit has been obtained.
5. Do you currently drive? ___Yes ___ No; If not, when was the last time you drove? _____
6. How many miles per year do you typically drive? _____ miles per year
7. Do you currently use special equipment/have modifications? ___Yes ___ No; If yes, List the brand name and configuration of the equipment: _____
8. Do you have any visual deficits? ___Yes ___ No; If yes, please be specific. _____
9. Do you have double vision? ___Yes ___ No.

10. Have you been diagnosed with homonymous hemianopsia? ___ Yes ___ No.
If yes, please provide Humphrey's Field Analysis, if available.
11. Do you have any endurance issues that we need to be aware of? ___ Yes ___ No; _____
12. Do you have good control of your arms? ___ Yes ___ No; Legs? ___ Yes ___ No.
13. Is one side of your body, i.e., arm or leg, stronger than the other? ___ right arm ___ left arm
___ right leg ___ left leg
14. Is your strength good in your hands? ___ Yes ___ No; Shoulders? ___ Yes ___ No.
15. Can you walk? ___ Yes ___ No; If so, how far can you walk at one time? _____
16. Do you use a wheelchair? ___ Yes ___ No; Is it a Manual chair ____, or Power chair ____
17. What is the brand name of the wheelchair? _____
18. Do you have a 3 or 4-wheeled scooter? ___ Yes ___ No; Type/Brand _____
19. Have you been to our office before? ___ Yes ___ No
20. Can you transfer from wheelchair/scooter to the driver's seat? ___ Yes ___ No.
21. Does the transfer have to be level surface? ___ Yes ___ No.
22. Can you get in/out of a SUV/Truck independently? ___ Yes ___ No.
23. Is this evaluation due to your vehicle needing *modification updates*? ___ Yes ___ No.
24. What type of vehicle will/do you drive? ___ Car, ___ SUV, ___ Truck or ___ Van (select one or more)
25. Our hours of operation are generally Monday-Friday 8am to 5pm. Are there any scheduling restrictions or preferences you have? _____

FUNDING SOURCE - YOU MUST SELECT ONE OF THE OPTIONS BELOW:

- A) Self-Pay _____ UKHDI DOES NOT FILE HEALTH INSURANCE. Private health insurance requires payment at time of services before filing for reimbursement.
- B) Worker's Comp _____ For Worker's comp and Trust payor's, UKHDI REQUIRES AUTHORIZATION OR Trust. Case Manager: _____ Phone: _____
Email: _____ Fax: _____
- C) Vocational Rehab or Veterans Administration REQUIRES an Authorization
Counselor: _____ Phone: _____
Email: _____

UKHDI - DRIVER CONSENT FORM

Consent Must be Completed, Signed and Submitted BEFORE an Appointment Will Be Scheduled

UNIVERSITY OF KENTUCKY HUMAN DEVELOPMENT INSTITUTE (UKHDI) Driver Rehabilitation Program is an Occupational Therapy Provider. As such, we require a physician's referral (for OT licensing purposes), a valid license or permit (to properly evaluate the driver on public streets), and pre-approved financial coverage. This questionnaire will help us establish your basic functional level and customize the evaluation and training program for you. Thank you for your assistance in this matter. Call if you have any questions.

CANCELLATION/NO SHOW POLICY: University of Kentucky Human Development Institution. (UKHDI) requires 24-hour notice for cancellation of a scheduled appointment. Failure to do so may result in a partial charge of the scheduled services. We understand that there are extenuating circumstances, which will be taken into consideration on a case-by-case basis.

COMPLAINTS: Any grievances not resolved by UKHDI may be forwarded to Christina Espinosa, Program Director ctespinosa@uky.edu

- 1.) I, _____, agree to undergo a comprehensive driver evaluation, and possible training, by the (Certified Driver rehabilitation Specialist/Driving Rehabilitation Specialist) CDRS/DRS of University of Kentucky-Human Development Institution. hereinafter referred to as (UKHDI), for the purpose of determining my ability to safely operate a motor vehicle. I consent and agree to participate in all of the evaluation procedures that (UKHDI CDRS) feels appropriate in determining my ability to drive safely.
- 2.) I understand that operating a motor vehicle on public roads is a privilege, not a right, granted to me by the State of Kentucky and its Department of Transportation. The KY Medical Review Board has its own laws and regulations concerning the operation of motor vehicles. I further understand that the program may not provide training in all areas of motor vehicle operations and that I am solely responsible for the safe operation of motor vehicles in accordance with all applicable laws and regulations when I am behind the wheel of all motor vehicles I operate.
- 3.) I understand that safely operating a motor vehicle requires good physical control of the vehicle, as well as good visual, perceptual, and cognitive skills by the driver in order to react to ever-changing surroundings and the driving environment. I understand that my medical diagnosis may impair my driving ability, thus my participation in this driver evaluation/training/education program presents risks to me such as, but not limited to, my involvement in a motor vehicle accident. I voluntarily assume these risks and will not hold (UKHDI) liable for any incidents in which my individual actions could cause harm to myself or others.
- 4.) I consent to allow (UKHDI) to inform my referring physician(s) and any 3rd party payor of the results of this evaluation and all subsequent training. My referring physician and the (UKHDI) staff will also inform the Kentucky Medical Review Board of the results of my evaluation/training should it be deemed appropriate for safety concerns to the community or myself, and when required by law to do so. I give my consent to all such disclosures with an awareness that such disclosures may result in the suspension or revocation of my license to drive or prevent me from obtaining a license to drive in the future.
- 5.) I understand the authority to revoke or suspend or affect my license in any way rests solely upon the Kentucky Transportation Cabinet or Medical Review Board.
It is ultimately the Kentucky Transportation Cabinet who determines my licensing status.
- 6.) I certify I have provided the (UKHDI) staff with the most up-to-date and accurate medical history available.

- 7.) I agree to abide by the recommendations given by the (UKHDI) CDRS/DRS upon completion of the comprehensive driver assessment and or training. These recommendations may include vehicle and adaptive equipment requirements, a series of driver education or training lessons, a request for further medical consultation or therapies to determine whether additional treatment is necessary, or a report to my referring physician or Kentucky Transportation Cabinet / Medical Review Board recommending revocation or suspension of my license as deemed appropriate. I agree to cease driving immediately if the (UKHDI) CDRS believe it is unsafe for me to continue driving.
- 8.) I am solely responsible for adhering to and accomplishing all (UKHDI) CDRS/DRS recommended actions and understand that documentation of my ability to drive a motor vehicle will be contingent upon my completion of all such recommendations within the time perimeters and/or expiration dates given.
- 9.) Each evaluation or training session will be paid upon completion and or billed to a 3rd party paying source according to (UKHDI) procedures. I understand that (UKHDI) does not in any way, bill insurance and that I am solely responsible for any and all of the bills not paid by my agreed upon 3rd party payor, IF APPLICABLE.
- 10.) I give permission to be photographed and/or videotaped during my session as the (UKHDI) CDRS/DRS see's fit for educational and/or documentation purposes, if applicable.
- 11.) I release and hold harmless the (UKHDI) staff, their agents, employees, contractors, and support staff from any and all claims arising out of my participation in this driver evaluation/training program. I further understand that the driver trainers, therapists and/or staff may, in their professional judgement, terminate my participation in this program at any given time.
- 12.) I agree to contact the Driver Program immediately should there be any change in my condition that affects my ability to drive.

Client Signature:

Date Signed:

(Staff or CDRS to Sign During Intake Appt.)

(UKHDI) Staff or CDRS Signature:

Intake Date Signed: