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| **Occupational Therapy Driving Assessment ICRS**   |  | | --- | | *Patient sticker* | |   **Date of assessment……………………**  **Assessor…………………………………**  **Time……………………………………….**   |  |  | | --- | --- | | Role Explained Yes / No | Consent Yes / No Written / Verbal / Implied |  |  |  | | --- | --- | | **Driving history** | | | Type of car usually driven? | Manual/ Automatic, car/ van/ HGV | | Licence type: |  | | Is driving required for employment? | Yes/ No | | Do you have any concerns regarding returning to driving? | Yes/ No | | Do you feel confident regarding returning to driving? | Yes/ No | | Have your family or friends expressed any concerns regarding you returning to driving? | Yes/ No | | Has anyone involved in your care expressed any concerns regarding you returning to driving? | Yes/ No | | What is the impact on you not currently being able to drive? |  | | Do you have any alternative transport options? | Yes/ No | | Is a family member able to take on driving duties? | Yes/ No |  |  |  | | --- | --- | | **Medical History** | | | Current conditions: |  | | Pre-morbid conditions: |  |  |  |  |  |  | | --- | --- | --- | --- | | **Fatigue** | | | | | Have you experienced fatigue since the stroke? | |  | | | How does this affect you? (times of day, severity of fatigue etc) | |  | | | **Physical ability** |  | | | | Upper limb’s (motor and sensory function) |  | | | | Lower limb’s (motor and sensory function) |  | | | | Neck and trunk mobility and stability: |  | | | | **Vision** | | | | | Have you had an eye test since the stroke? (if yes, what was their assessment of your vision?) | | |  | | Have you noticed any visual changes since the stroke? | | |  | | Do you wear glasses? If yes, what for? | | |  | | Did you have any issues with night vision prior to the stroke? | | |  | | **Visual screen**:   * Visual field loss: * Visual acuity: * Diplopia * Visual perception/ inattention: | | |  | | Is an orthoptic referral required: | | |  | | **Cognition** | | | | | Do you feel there have been changes to your cognition since the stroke? |  | | |  |  |  |  | | --- | --- | --- | | **Cognitive screening protocol explained to client:**  This is a cognitive driving screen and gives us an indication if the cognitive skills required for driving have been impaired. The screen is administered at 4-6 weeks after Stroke. If any issues identified then the screen can be repeated at 3 months following Stroke.  After 3 months screen if there are persisting cognitive issues, DVLA should be informed via STR1 form. The therapist may discuss a referral for a detailed on-road assessment to North West Driving centre.  **Therapist’s Initials:** | | | | **Cancellation task:** |  | | **Star Cancellation (A cutoff of < 44 indicates the presence of USN)**  Time limit- less than 5 min |  | | **Clock Drawing (>2 indicates impairment)** |  | | **Trail making test A** |  | | **Trail making test B ( normal score <90 sec)** |  |  |  | | --- | | **Summary and interpretation of results:** |  |  | | --- | | **Recommendations:** |   Please note – The cognitive assessments above are not definitive tools for predicting on-road performance. Scores outside of these acceptable cut-off scores are an indicator of compromised cognitive resources needed to drive safely and consequent failure in an on-road assessment.   |  |  | | --- | --- | | Is the patient in agreement with the recommendations? | Yes/ No |   **Signed: ………………………….. Name: …………………………………………. Date: ……………………** |  |