Lifetime SUPPORT

Medical Information Form: Assessment of Fitness to Drive a Powered Mobility Aid

INSTRUCTIONS: **This form is to be used as part of the assessment process to ensure a participant's safety in the use of a powered mobility aid.**

A medical practitioner must complete section 2. Once completed, return to:

Service Planner Name	Email	Phone

Postal Address: Lifetime Support Authority, PO Box 1218, ADELAIDE SA 5000

Further assessment will not proceed until this form is received by the above Service Planner. Please keep a copy for your own files.

1 Participant to complete

What this form is for

To provide details of any medical and eyesight conditions which may affect your ability to drive a powered mobility device.

Please note this approval is only the first stage in assessment and does not automatically qualify you for approval from the LSA to drive a powered mobility aid.

A practical driving assessment completed by your treating clinician will also be required.

What you need to do

You are required to action the following items:

- Make an appointment with your regular doctor for standard consultation.
- Explain to your doctor the reason for the visit.
- Complete only Section 1 of this form before handing it to your doctor.
- Take spectacles, hearing aids, the names of any medications you may be currently taking etc. to the appointment.
- Return the form to your Service Planner. Please contact your Service Planner if you are having any difficulty with the above steps.

Next Page

Participant Details

First Name

Surname

Phone

Date of Birth

Preferred Name

Gender

☐ M ☐ F ☐ Non-binary

Email

Home Address

Suburb

Postcode

Preferred Contact Number

Are you currently being treated by any *other* doctor or specialist for any reason? ☐ Yes ☐ No

Please indicate who & the reason:

Specialist/Doctor's name

Reason

I consent to my doctor, **Doctor's Name** releasing to the Lifetime Support Authority such medical or other information that may be required to assess my ability to drive a power mobility device.

Participant or Guardian Signature

Date

This completes Section One of the Form.

Section Two is to be completed by your doctor.
Once the entire form is completed, please return it to your Service Planner.

Next Page

2 Medical Practitioner to complete

IMPORTANT NOTES FOR THE MEDICAL PRACTITIONER:

To ensure participant safety and appropriate use, all participants seeking a powered mobility aid, are required to provide medical evidence of their fitness to undertake assessment and / or training in the use of a powered mobility device.

Because the skills required to operate a powered mobility device are similar to those required to operate a motor vehicle, the AustRoads guidelines 'Assessing Fitness to Drive' available at www.austroads.com.au may be a useful resource in completing this form.

Medical/Eyesight Information (To be completed by a Medical Practitioner)

I have personally examined Name of Participant

I am sufficiently familiar with the medical/optical condition of the person examined to enable me to complete this medical/optical information: ☐ Yes ☐ No

IMPORTANT POINT TO NOTE: Medical and eyesight standards are fully outlined in the publication "Assessing Fitness to Drive" found on the "Austroads" website – www.austroads.com.au

Does the Participant Have any of the following? (Please tick the appropriate boxes below)

1	Blackouts?	☐ Yes	☐ No
2	Cardiovascular Conditions?	☐ Yes	☐ No
3	Diabetes Mellitus?	☐ Yes	☐ No
4	Hearing Impairment?	☐ Yes	☐ No
5	Musculoskeletal Conditions?	☐ Yes	☐ No
6	Neurological Conditions?	☐ Yes	☐ No
7	Psychiatric Conditions?	☐ Yes	☐ No
8	Sleep Disorders?	☐ Yes	☐ No
9	Substance Misuse (including Alcohol, illicit drugs and prescription drug misuse)?	☐ Yes	☐ No
10	Vision and Eye Disorders?	☐ Yes	☐ No
11	Intellectual Disability/Cognitive Impairment?	☐ Yes	☐ No
12	Prescribed Drugs that may affect ability to operate a powered mobility aid?	☐ Yes	☐ No
13	Other condition, medical needs or consideration that may affect ability to safely operate a powered mobility aid?	☐ Yes	☐ No

If you answer 'YES' to any of the above please briefly describe below the present status of the medical condition, treatments currently or proposed to be undertaken (*including any medications*) and any other matter which may have a functional impact on the participant's ability to utilise a powered mobility device. Please note participant's weight & height details are required.

Maximum distance participant is able to walk (metres)		Participant's Weight (kgs)	Participant's Height (cms)
Aided:	Unaided:		

Next Page

Eyesight Information (Complete all sections below regardless of medical condition or age of participant)

EYESIGHT STANDARDS FOR DRIVING:

Eyesight required for operating a powered mobility aid in the community is similar to that required for driving. See details in Assessing Fitness to Drive' available at www.austroads.com.au/drivers-and-vehicles/assessing-fitness-to-drive

Binocular Vision	**Unaided:**	**6 /**	**Aided:**	**6 /**

Is the participant required to wear glasses, contact lenses or other visual aids while driving? ☐ Yes ☐ No

Comments:

Does the participant have normal visual fields on confrontation? ☐ Yes ☐ No

Comments:

Are any of the following conditions present? ☐ Yes ☐ No

Diplopia, Nystagmus, Loss of an eye, Fluctuating vision, Cataracts, Glaucoma, Retinitis pigmentosa, Poor night vision

OR Any other visual difficulty that may impact on powered mobility device use?

Comments:

If you have concerns regarding the above, consider referral to an Optometrist/Ophthalmologist for further assessment.

Next Page

I believe the participant requires the use of a powered mobility aid at this time? ☐ Yes ☐ No

In my opinion, the participant is medically fit to undertake assessment and/or training in the use of a powered mobility aid?

☐ No ☐ Yes, Unrestricted ☐ Yes, Restricted

If YES, RESTRICTED, please tick appropriate box:

☐ Supervised ☐ Only within home /own grounds ☐ Other:

Medical Practitioner Declaration

Name of Medical Practitioner

Provider Number

Address

Suburb

Postcode

Daytime Phone No.

Medical Practitioner Signature

Date