

Driver Evaluation Program

Referral Information:

- 1. A physician’s order/prescription for an O.T. Evaluation for Driving is required.**
The order should be faxed in advanced or sent through the mail. By hospital policy, the therapist cannot perform the evaluation without a written MD order. The order should state “O.T. Evaluation for Driving.” If faxed over, please mark to the attention of the Driving Program at fax # 781-933-9257. Blank prescription enclosed.
- 2. A current driver’s license or instructional permit is required to participate in the program.**
You will be asked your driver’s license number or permit number when calling to schedule an appointment, your license status will be verified prior to your appointment.
- 3. A referral must be created in the NERH scheduling system.**
To begin the referral process basic information such as name, address, date of birth, diagnosis, primary care physician (PCP) information, etc. is required. Please call our office at (781) 939-1900 to schedule appointments.
- 4. An appointment is reserved for that client for Part 1 - Clinical Assessment.**
The clinical portion of the evaluation takes one hour. Please arrive 30 minutes prior to your evaluation time to complete the registration process. Have your driver’s license or learners permit, glasses, and MD order available **as well as payment.** (\$150.00 payable to NERH)
- 5. After successful completion of Part 1 – Clinical Assessment, Part 2 – On the Road Assessment is scheduled at a later date. Part 1 (Clinical Assessment) and Part 2 (Road Assessment) are never done on the same day.**
The Part 2 - On the Road Assessment takes approximately 1 hour. Please arrive 15 minutes prior to your evaluation time to complete registration process. Please bring with you a current drivers license or permit, MD order (if not faxed over prior), current list of medications, glasses, and payments. If you do not have your current driver’s license or permit on hand – you will be unable to participate in the Road Assessment.
- 6. The Driver Evaluation Program is a private pay fee for service program.**
SEPARATE PAYMENTS REQUIRED FOR NERH & ADAPTIVE DRIVING SCHOOL.
The cost of the program is:

\$150.00	Part One Clinic Evaluation
\$150.00	Part Two Road Evaluation
<u>\$150.00</u>	Driving School Vehicle and Instructor (Adaptive Driving Program, Inc)
\$450.00	

***Separate Checks NERH and Adaptive Driving Program**

**Prices subject to change with proper notice*

- A receipt will be issued in order to assist our clients seeking reimbursement from a third party.
- Clients who are actively involved with the Mass Rehabilitation Commission may have their driving evaluations funded by that source.

Directions to:
New England Rehabilitation Hospital
Outpatient Center at Woburn
2 Rehabilitation Way
Woburn, MA 01801
781-939-1900



1. Take Route 128 / 95 from either direction to exit 33A towards Woburn / Winchester.
2. The hospital driveway is 2.2 miles from Route 128 / 95 on your left at the Woburn / Winchester line.
3. To access the driveway, go beyond it and beyond Whole Foods Market and to make a UTurn.
4. Look for a NEW ENGLAND REHABILITATION HOSPITAL sign and take a right into the driveway.
5. Follow signs for Ambulatory Care, the Outpatient Center and parking is located around the back of the building.

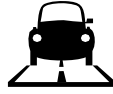
Important numbers to know:

Outpatient Office Line

781-939-1900

Fax #

781-933-9257



New England Rehabilitation Hospital's Driver Evaluation Program has been established to provide assessment of individuals with a variety of disabilities in order to facilitate independent mobility within the community.

The Driver Evaluation Program includes many components to assess the patient's driving skills and works in conjunction with the treating physician. There are two parts of the evaluation; if the patient successfully completes the clinical assessment – Part 1, then the on-the-road portion is scheduled at a later date.

**The Driver Evaluation Service consists of 2 one-hour sessions.
Clinical Assessment and Road Assessment completed on 2 separate days.**

Part One: Clinical Assessment

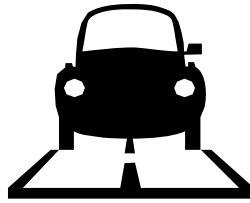
- Completed by an Occupational Therapist
- Visual Acuity including depth perception and peripheral vision
- Cognitive/ Perceptual – spatial relations, right/left discrimination, color and sign recognition, problem solving, sequencing, attention, scanning, following directions.
- Physical Mobility – joint range of motion, muscle strength, tone, coordination, balance, sensation, endurance, level of functional ability.
- Indoor Driving Simulation – reaction time, knowledge of traffic situations.

Part Two: Road Assessment

- Completed with a Certified Driving Instructor and an Occupational Therapist
- A behind the wheel assessment of the patient's ability relative to driving and the use of adaptive equipment, if indicated. The assessment takes place in a driving school vehicle equipped with an instructor's brake and adaptive equipment as needed. A formal feedback session takes place after the evaluation between the patient, therapist, and driving instructor. Written recommendations are provided.

Admission Criteria

- Must meet Massachusetts RMV standards for visual acuity and peripheral vision.
- Free of seizure activity in the past six months.
- Current driver's license or instructional permit is required for participation in the program.
- A six-month waiting period after a medical condition has occurred is recommended for some patients prior to participation in the program.
- A physician's order is required for an occupational therapy evaluation for driving.



Why Choose A Driver Evaluation Program?

Massachusetts Registry of Motor Vehicles (RMV) policy states:

“If a licensee has a medical condition which he or she believes may affect his or her ability to operate a motor vehicle, he or she must report such condition to the Registrar and refrain from operating a motor vehicle until the condition is resolved.”

A driver evaluation can determine whether or not the medical condition ***“affects ones ability to operate a vehicle”*** and whether or not the ***“medical condition is resolved.”***

To schedule an appointment: 781-939-1900

New England Rehabilitation Hospital

2 Rehabilitation Way, Woburn, MA 01801

781-939-1900 – FAX: (781) 933-9257

Occupational Therapy Driving Evaluation Prescription

In order to properly evaluate your patient, please provide us with a brief history and FAX back to us. This form also serves as your referral for therapy services.

Patient Name: _____ D.O.B.: _____ Date: _____

Patient Address: _____

Phone: _____ Insurance: _____

Diagnosis: _____ Approx. Onset: _____

Current Drivers License: Yes _____ No _____

Pertinent Medical History:

Please indicate if any of the following medical issues are pertinent:

- | Yes | No | | Yes | No | |
|--------------------------|--------------------------|---|--------------------------|--------------------------|-----------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures: Most recent seizure date: _____ | <input type="checkbox"/> | <input type="checkbox"/> | ETOH Abuse |
| <input type="checkbox"/> | <input type="checkbox"/> | Medications (i.e. sedatives) | <input type="checkbox"/> | <input type="checkbox"/> | Visual Deficits |
| <input type="checkbox"/> | <input type="checkbox"/> | Behavioral Problems | <input type="checkbox"/> | <input type="checkbox"/> | Poor Endurance |
| <input type="checkbox"/> | <input type="checkbox"/> | Implanted Cardiac Defibrillator: Most recent trigger date: _____ | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | O2 Saturation levels 88% or less at rest or with minimal exertion | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | FEV-1 Level of 1-2 liters or less | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis condition which renders the individual unable to perform self care. | | | |

Other: _____

In order to streamline the evaluation when appropriate, please identify the areas of concern you wish to have evaluated:

- | Yes | No | |
|--------------------------|--------------------------|-------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Physical Issues / Adaptations |
| <input type="checkbox"/> | <input type="checkbox"/> | Vision / Perception |
| <input type="checkbox"/> | <input type="checkbox"/> | Cognition |

Is the patient currently receiving therapy services? _____ Where? _____

Is the patient involved with the Massachusetts Rehabilitation Commission?: _____ Yes _____ No

Referring Physician: _____
Address: _____
Phone: () _____ Fax: () _____
Physician Signature: _____
My signature authorizes this treatment to be medically necessary