|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| As powered wheeled mobility aids (scooters/wheelchairs) are used in community settings and public thoroughfares, safe usage is important. The application process for requesting a powered mobility aid through the Territory Equipment Program (TEP) requires the completion of this Optometry Assessment by a suitably qualified Optometrist or Ophthalmologist to ensure that there are no vision conditions that would affect the client’s ability to use the aid safely. | | | | | | | | | | | | | | |
| **Client Details** | | | | | | | **Client ID:** | | | | |  | | |
| Given Names: | |  | | | | | Surname: | | | | |  | | |
| Date of Birth: | |  | | | | | Phone: | | | | |  | | |
| Equipment Required/Used: | | | |  | | | | | | | | | | |
| **Optometrist/Ophthalmologist Details (Assessor)** | | | | | | | | | | | | | | |
| Name: | | | | | | | | Phone: | | | | | | |
| Qualification/Provider Number: | | | | | | | | | | | | | | |
| Address: | | | | | | | | | | | | | | |
| **Assessment** | | | | | | | | | | | | | | |
| Visual Acuity, **unaided** | | | R 6/ | | | L 6/ | | | | | | | Binocular 6/ | |
| Visual Acuity, **aided** | | | R 6/ | | | L 6/ | | | | | | | Binocular 6/ | |
| **Condition** | | | | | | Yes | | | No | | Comments | | | |
| a. | Are corrective lenses to be worn when driving? | | | | |  | | |  | |  | | | |
| b. | Does the client have poor night vision? | | | | |  | | |  | |  | | | |
| c. | Does the client suffer from double vision (diplopia) | | | | |  | | |  | |  | | | |
| d. | Is there a visual field defect?  If Yes, indicate type and extent in degrees along a horizon midline | | | | |  | | |  | |  | | | |
| e. | Does the client have a progressive eye condition? If yes, please state. | | | | |  | | |  | |  | | | |
| f. | Does the client meet the visual criteria to hold a licence to drive a car?  (in accordance with national Medical Standards for Licensing\*) | | | | |  | | |  | |  | | | |
| g. | Are any further tests or follow up required? | | | | |  | | |  | |  | | | |
| \*Assessing Fitness to Drive – for commercial and private vehicle drivers. Medical Standards for Licensing and Clinical Management Guidelines. March 2012 National Transport Commission Australia and Ausroads. Part B:10 Vision and eye disorders. http://www.austroads.com.au/assessing-fitness-to-drive | | | | | | | | | | | | | | |
| **Declaration**  I confirm that I have carried out an eyesight assessment and that the above named client:  has adequate vision (with or without correction) to safely drive a powered mobility aid; or  has inadequate vision (ongoing or pending further tests) to safely drive a powered mobility aid. | | | | | | | | | | | | | | |
| Assessor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | |
| Please send completed assessment to: | | | | |  | | | | | by fax/email: | | | |  |

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