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| 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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