TUALITY HEALTHCARE
An OHSU Partner

Name of person filling out form _____ Patient's Name_____

Caregiver/Family Questionnaire

Please mark yes or no to the following behaviors you have observed or know about regarding the person is who being referred for a driver evaluation.

1. Incorrect signaling YES NO

2. Pulls out into traffic when other cars are approaching YES NO

3. Has difficulty keeping the car in the lane, crossing over the lane line or drives using two lanes so that other cars cannot use a driving lane safely. YES NO

4. Drives too slow or fast. YES NO

5. Has difficulty making decisions to proceed after stopping at a stop sign or light. YES NO

6. Has driven through a red light or a STOP sign. YES NO

7. Has been stopped by a police officer. YES NO

8. Has received a ticket or warning from a police officer. YES NO

9. Has been involved in an accident while driving. YES NO

10. Has stopped in traffic for no apparent reason. YES NO

11. Has gotten lost while driving. YES NO

12. Seems nervous after driving or while driving. YES NO

13. Please let us know of any other concerns you have regarding the person referred ability to drive.

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