

NOTE: Please complete all sections in BLOCK CAPITALS. If an interpreter is required, this will need to be arranged privately. Please note the patient needs to hold a valid driving licence to be eligible for a driving assessment. Please advise your patient that if they do not meet the visual standard for driving (reading a number plate at 20 meters) the DVLA will be informed, and this could likely result in their licence being revoked.

patient details

Title Name D.O.B

Gender Female Male Non-Binary Prefer not to say

Address

Postcode

Phone Number Email

alternative contact details

Name Relationship

Address

Postcode

Phone Number Email

Patient prefers us to contact this person: Yes No

Patient would like their appointment letter copied in to this person: Yes No

referrer details

Name Role

Address

Postcode

Phone Number Email



driving details

Does the patient have a valid driving licence? Full Provisional No current licence

Has the patient informed the DVLA of their medical condition? Yes No

Date of when? (please ensure your patient has informed the DVLA of any notifiable condition)

Has any health professional told them to stop driving? Yes No Whilst awaiting Ax

medical information

Confirmed diagnosis:

When did the condition start?

Reason for referral (please explain why your patient is being referred and list any supporting information or results of cognitive tests if you feel necessary):

Physical Impairments (if any): (i.e. can they transfer into a vehicle without assistance):

Has your patient given consent for this referral? Yes No

Cognitive impairments identified? Yes No

Please provide details and any relevant cognitive testing completed:

Is your patient ready for assessment? Yes No



If no, please provide details as to why. Please note if your patient isn't ready for an assessment within the next 3 months you will need to refer them nearer the time.

GP details

Is the patient still under your caseload? Yes No

If no, please provide GP details so that we can send a copy of the report to the GP otherwise the report will be sent to you and the patient.

Name Role

Address

Postcode

Phone Number Email

Referral for: Car Assessment Motorbike Assessment HGV/LGV/PSV Assessment
Powered Wheelchair and Mobility Scooter

booking information

Which Centre would you like to attend?

Accrington Hull Oxford Solihull
Ashton Leicester Scunthorpe Wolverhampton
Aylesbury Manchester Shrewsbury Worcester
Cannock Northhampton Stoke Mandeville

If there is any other information you think would help us with your patients booking?

Signature Date

freedom to move

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