Social care referral form

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 eligable 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 ◯

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