Healthcare Professional Driving Assessment Referral Form

Please complete all sections.

Referrer name: …… Tel: ……..

Referrer professional title…….....

Address: …….....

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……Post Code……..

Patient's name: …….. DOB: ……

Address: …….....

……

……Post Code……..

Tel: …….

Diagnosis / PMH: …….

Medication: ……..……..

Reason for referral: …….

Please list impairments or relevant facts that may have the potential to affect your patient's ability to drive safely. Please consider cognitive impairment / visual deficit / physical limitations / perception and communication needs including receptive and expressive difficulties:

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Have you advised the patient to inform the DVLA? Yes / No

https://www.gov.uk/guidance/current-medical-guidelines-dvla-guidance-for-professionals

Have you told the patient to stop driving? Yes / No

Is the patient fully aware of these facts? Yes / No

Has the patient given their consent to this referral? Yes/ No

In your opinion, is your patient able to give informed consent? Yes/ No

Date of referral …… Signature……..…….

Please return to: Email: mobserv@drivingandmobility.org

Or: Post: Driving and Mobility Centre (West of England)

The Vassall Centre, Gill Avenue, Fishponds, Bristol BS16 2QQ
0117 965 9353