

Driving and Mobility Centre (West of England)
The Vassall Centre, Gill Avenue, Fishponds, Bristol BS16 2QQ
Telephone 0117 965 9353 Fax: 0117 965 3652

ASSESSMENT APPLICATION FORM (tick relevant box)

EQUIPMENT HOIST **PASSENGER** **SCOOTER**

PERSONAL DETAILS

Surname Mr/Mrs/Ms/Miss.....

Forenames.....

Address.....

.....

.....Postcode.....

Telephone Number.....

Contact number for making appointment (if different from above).....

Date of Birth.....Age at assessment.....

Your Height.....Your Weight.....

Name and contact Tel No. in case of emergency.....

HOW DID YOU HEAR ABOUT US – PLEASE TICK BOX

Been Before		Disable Driver Group		Disability Group		Doctor	
Driving Instructor		DVLA		Other Mobility Centres		Garage/Adaptor	
Motability		Others		Therapists SSD		Publications/Media	
Social Worker Services		Solicitors		Therapists Health		Friends/Relations	

ETHNIC ORIGIN - PLEASE TICK ONE BOX

(These are the categories used in the National Census 2001)

White	Mixed	Asian or Asian British	Black or Black British	Chinese or other ethnic group
British	White and Black Caribbean	Indian	Caribbean	Chinese
Irish	White and Black African	Pakistani	African	Any other
Any other White Background	White and Asian	Bangladeshi	Any other Black background	
	Any other mixed background	Any other Asian background		Would prefer not to say

EQUIPMENT

What equipment would you like to be assessed for?

.....

NATURE OF DISABILITY OR MEDICAL CONDITION

**(Information about your medical condition
helps us make an accurate assessment
and ensures we have correct equipment available)**

Please specify any medical condition and how it affects you.

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Please specify any mobility difficulties experienced.

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Are you currently on any medication?

YES / NO

If YES please state name and dosage.....

.....

.....

.....

Have you enclosed a Medical Report?

YES / NO

MOBILITY DETAILS

Do you use a wheelchair? YES / NO

If YES please state what type of wheelchair you are currently using

.....

If YES how do you transfer into and out of it?

.....

.....

Do you require the help of another person with daily activities? YES / NO

.....

Do you use a hoist? YES / NO

If YES what type are you using?

.....

Do you have a carer? YES / NO

If YES does your carer have any difficulties?

Are you currently a: - Driver / Passenger / or both within a vehicle
(Please circle option(s) that apply)

What make / model of car do you regularly use?

.....

Do you receive Mobility Allowance or PIP? YES / NO

If YES what rate is it? HIGHER / LOWER

APPOINTMENT PREFERENCE: Morning Afternoon

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Telephone 0117 965 9353 Fax: 0117 965 3652
Community Interest Company No: 2848685

REQUEST FOR CONSENT TO OBTAIN MEDICAL INFORMATION

I give my consent for Driving and Mobility Centre to contact my General Practitioner/Consultant for any further medical information relevant to this assessment. This will be treated in strict confidence. I understand that a copy of the report will be sent to the doctors providing the information.

Signed.....Date.....

Name (please print).....

Name of General Practitioner.....

Address.....

.....

.....Postcode.....Telephone.....

and / or Consultant.....

Address.....

.....

.....Postcode.....Telephone.....

It may be necessary in some instances to contact the DVLA or Motability for clarification about your driving status.

Data Protection Act 1984 (Important: Please sign this section so that we can proceed with an assessment. If you have any questions, please contact the Centre)

I understand and agree that Driving and Mobility Centre are required by its funders to produce statistics about, analysis of, and occasionally research into, the services provided. To facilitate this, my personal information will be held confidentially on computer and paper files at Driving and Mobility Centre for 7 years and then securely destroyed. This information will NOT be transmitted to any other organisation or department unrelated to Mobility Assessments.

Signed:.....Date.....

Thank you for completing the above details.
Please return the form to the above address.