Healthcare Professional Driving Assessment Referral Form

Please complete all sections.

Patient's name: ……………………………………………………………….. DOB: …………………

Address: ……………………………………………………………………………………………………

…………………………………………………………Post Code……………………………………………..

Tel: ………………………………………………………………………………………………………

Diagnosis: ……………………………………………………………………………………………

Reason for Referral: …………………………………………………………………………………

PMH: ………………………………………………………………………………………………………..

………

Medication: ……………………..……………………………………………………………………..

………

Please list any cognitive, visual/perceptual, physical impairments and communication difficulties:

………

………

………

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

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

Referrer's name: ………………………………………… Tel: …………………………………..

Referrer professional title……………………………………………………………………………

Address: ……………………………………………………………………………………………………

…………………………………………………………………….Postcode: ………………………………

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