

# 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](mailto:mobserv@drivingandmobility.org)

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

***Please note: No fee is payable to the referring Healthcare Professional***