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

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 This section **must** be completed.

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 on computer and paper files at Driving and Mobility Centre. 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.
Company Limited by Guarantee No. 2848685

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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					

EQUIPMENT

What equipment would you like to be assessed for? ……

……

What difference do you hope this equipment will make to your life?.....

.....

How do you think this equipment will help you? .....

.....

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.

.....

.....

Please specify any mobility difficulties experienced.

……..

……..

Are you currently on any medication? YES / NO

If YES please state name…….

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