

Healthcare Professional Driving Assessment Referral Form

Please complete all sections.

Referrer name: Tel:

Address:

.....

.....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>

Is the patient fully aware of these facts? 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