



## Application for a Driving Ability Assessment

*Please read before completing the application form.*

Please find to follow an application form for a Driving Ability assessment.

This assessment is designed for drivers whose disability arises as a result of a neurological condition such as a stroke or a head injury. It is also a suitable safety check for the responsible older driver.

If this is the type of assessment you require please complete the application form and return it to the address at the top of the form as soon as possible. Please note that we cannot accept application forms via email. If you are self paying please enclose a cheque made out to 'QEF Mobility Centre', if someone else is paying for the assessment please give their details on page 4 of the application form. **Please call us on 020 8770 1151 or email [info@mobility-qe.org](mailto:info@mobility-qe.org) for the cost of the assessment and to ensure this is the correct assessment for your needs.**

When we have received the completed form we will send you an appointment. We will also send you a map with directions of where to find us, and a programme of what you can expect on the day. The assessment will last approximately 4 hours.

The Mobility Centre has the benefit of being able to offer you an appointment with a short waiting time of approximately 6 weeks from when we receive your application form.

Following your assessment we provide a summary report which is sent to the appropriate parties.

We also hold information which may be useful to you when coming to the Mobility Centre such as a list of organisations which may be able to provide transport to bring you to us, a list of local accommodation and details of organisations who may be able to help with funding. If you require any of this information please get in touch.

If this does not appear to be the type of assessment that you require or if you have any other queries over the assessment process please call us on 020 8770 1151.

We look forward to receiving your completed application form.

Administrator  
Queen Elizabeth's Foundation Mobility Centre



**DRIVING ABILITY ASSESSMENT APPLICATION FORM**  
*(Downloaded from [www.qef.org.uk](http://www.qef.org.uk))*

**PAYEE.....**

*(please complete using CAPITALS and return to the above address)*

**SURNAME (MR/MRS/MISS/MS) . . . . . FORENAMES . . . . .**

**ADDRESS . . . . .**

**COUNTY . . . . . POSTCODE: . . . . .**

**TEL (home) . . . . . (work). . . . . (mobile) . . . . .**

**If we have to call you and you are not available may we leave a message? YES/NO**

**EMAIL . . . . . DATE OF BIRTH . . . . .**

Due to central Government Funding, we need the following information for research purposes:

- Ethnic Origin:** Asian Bangladeshi ( ) Asian Indian ( ) Asian Other ( ) Asian Pakistani ( )  
 Black African ( ) Black Caribbean ( ) Black Other ( ) Chinese ( ) Declined to comment ( )  
 Ethnic Other( ) Mixed Other( ) Mixed White + Asian ( ) Mixed White + Black African Mixed ( )  
 Mixed White + Black Caribbean ( ) White British ( ) White Irish ( ) White Other ( )

What is the nature of your disability? . . . . .

Date of onset . . . . . Do you experience any pain? . . . . .

Please give brief details . . . . .

Are you in receipt of the higher rate mobility component of Disability Living Allowance? **YES/NO**

How did you hear of us? . . . . .

Have you been assessed by this Mobility Centre before? **YES/NO** (year )

**TYPE OF ASSESSMENT**

**£..... Driving Ability** with Car Adaptation, if applicable  
*(for those with neurological damage, e.g. Cerebral Palsy, Stroke, Head Injury, Spina Bifida/Hydrocephalus, Dementia/ Memory loss/ Frail/ Elderly/ Compromised immune system etc)*

**Please call us on 020 8770 1151 or email [info@mobility-qe.org](mailto:info@mobility-qe.org) for the cost of the assessment and to ensure this is the correct assessment for your needs. Thank you.**

If you are unsure if this is the appropriate assessment, please ring to discuss.

General Practitioner/Consultant . . . . .

Address . . . . .

County..... Post Code . . . . . Telephone . . . . .

**DRIVING EXPERIENCE AND LICENCE DETAILS** (please circle your answers)

Have you ever held a Driving Licence?      YES / NO      if YES:    PROVISIONAL / FULL

IF YOU HAVE HELD A FULL LICENCE

Licence number (if known) .....      Expiry Date .....

Number of years' driving experience? .....

Have you driven other groups of vehicles? e.g. LGV, PCV, 2 Wheeled Motorcycle .....

**PLEASE BRING YOUR LICENCE WITH YOU**

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**IMPORTANT: If you already hold a driving licence and you develop a medical condition which could affect safe driving, then you are legally required to inform the DVLA. We may be unable to carry out the on-road drive part of your assessment if this has not been done.**

Have you informed the DVLA of your disability?      YES / NO

If YES, what is the present situation?      *please tick*

- a) Your case is still being investigated by DVLA      [   ]
- b) Your licence has been revoked      [   ]
- c) The DVLA have allowed you to continue driving      [   ]
- d) You have been issued with a Provisional Disability Assessment Licence [   ]
- e) You returned your licence voluntarily when you informed the DVLA      [   ]

**If (e) you may need to re-apply for your licence prior to the assessment date to carry out a full assessment drive.**

Have you re-applied to DVLA for a licence?      YES / NO

If YES, what was the reply?.....

For research purposes we may contact the DVLA after your assessment to ascertain your licensing status. If you prefer us not to do this, please tick here [   ]

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Car Make .....      Model .....      Year .....

Automatic / Manual      Estate / Saloon / Hatchback

Does it have any adaptations?      YES / NO

If YES, please specify .....

Do you currently encounter any problems with driving? If yes, please specify:.....

Are you driving at the moment?    YES / NO    If YES, approximately how many miles per week?.....

For your assessment would you like to drive a manual or automatic car? (Please tick)  
Manual    [   ]      Automatic    [   ]      (Subject to assessors final decision)

**MEDICAL INFORMATION** *please circle your answers*

**1 Have you had a head injury / period of unconsciousness / brain surgery?** YES / NO  
If YES, please give date and details.....

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**2 Have you ever had epilepsy?** YES / NO  
If YES, when was your last attack? .....

.....

**3 Do you have episodes of fainting?** (other than simple attacks associated with the sight of blood or disturbing news, etc) YES / NO

If YES, please give date of last attack .....

.....

**4 Do you have dizziness or vertigo** (exceptions as above) YES / NO  
If YES, please give date of last attack.....

.....

**5 Do you have diabetes?** YES / NO  
If YES: a) Is it controlled by insulin? YES / NO  
b) Is it controlled by tablets? YES / NO  
c) Have you ever had a hypoglycaemic attack? YES / NO

If YES, please give date of last attack.....

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**6 Sight**  
Do you have any defect of vision (other than requiring correction by spectacles)? YES / NO

If YES, please give details .....

.....

**IF YOU WEAR GLASSES, PLEASE BRING THEM WITH YOU**

**7 Medication**  
Please give details of any pills or medicine you take and **bring them with you**

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**8 Have you been prescribed any medication which you do not take for any reason?** YES / NO

If YES, please state .....

*Continue on page 4*

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**FOR OFFICE USE ONLY:**

Driver's Name (Capitals) ..... Driver's Signature .....

Assessor's Signature ..... Date .....

**LIFESTYLE INFORMATION** *please circle your answers*

Do you require assistance for:

- Personal care? YES / NO (details) .....
  - Domestic tasks? YES / NO (details) .....
  - Outdoor mobility? YES / NO (details) .....
- Are you working? YES / NO (details) .....

How has your condition caused you to alter your lifestyle, employment situation or leisure activities?

.....  
.....

Can you independently transfer into and out of a car? YES / NO

Do you need equipment/ assistance to transfer? YES / NO

If yes, please give details.....

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Are you a wheelchair user? YES / NO

If YES, please state whether your chair is: MANUAL / ELECTRIC (please delete as applicable)

Name/ Type of wheelchair:.....

Can you independently load/ unload your wheelchair into a vehicle YES / NO

**DECLARATION**

I give my consent for Queen Elizabeth’s Foundation Mobility Centre to contact my Doctor, should it be considered necessary, for any further medical information relevant to this assessment. This will be treated in strict confidence. I understand a copy of the report may be sent to my Doctor.

I agree to participate in the assessment and understand this may involve some physical contact by assessing staff and that they may take photos for assessment purposes.

I accept that if I fail to attend my appointment or if I do not give at least 5 working days’ cancellation notice, the fee will not be refunded. There will be a 25% administration charge for all cancellations if another appointment is not required.

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

**PAYMENT**

I enclose CHEQUE for £ ..... made payable to “QEF Mobility Centre”. (We accept cheques, postal orders or cash but are unable to accept credit or debit cards). Please put your card number and address on the back of your cheque.

*If you are not paying for the assessment yourself, please list below the name and address of the person / organisation who has agreed to meet the cost of the assessment.*

Name (person / organisation) .....

Address .....

..... Post code: .....

Contact name ..... Tel: .....