Sent/Initials: .....

QEF Mobility Services
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DRIVING ASSESSMENT APPLICATION FORM

USING CAPITAL LETTERS, PLEASE RETURN THIS COMPLETED FORM AS SOON AS POSSIBLE AS WE ARE UNABLE TO BOOK APPOINTMENTS WITHOUT IT.

We need this information to provide you with our services, and although data may be shared for healthcare purposes, vital interests, legal reasons or public interest, it will not be shared for marketing purposes without your explicit consent. For more detailed information on how we process your data and keep it secure, you can visit our website at https://www.qef.org.uk/privacy or contact the office by email or phone.

(Tick one box)

☐ Self-referral ☐ DVLA referral ☐ Motability referral ☐ QEF referral

For office use only:

Part A. PERSONAL INFORMATION	
TITLE: FORENAME:	**SURNAME:**
DATE OF BIRTH: / /	**EMAIL:**
ADDRESS: **POSTCODE:**	**Contact Tel (1)** **Contact Tel (2)**
Please give brief details of your disability/medical condition and how it affects your driving (if necessary, please continue on a separate sheet):	
OFFICE USE ONLY: Notifiable: YES/NO	
Date of onset:	Do you experience any pain? **YES/NO**
Have you informed the DVLA of your disability/medical condition? **YES/NO**	
Have you been assessed by QEF or another Driving Mobility accredited centre before? **YES/NO** If **YES**, which centre and in what year? Please send a copy of the report with your application if you have been seen by another centre How did you hear about us?	

Part B. DRIVING EXPERIENCE AND LICENCE DETAILS ***(please tick as appropriate)***			
Is this an assessment for:			
a car		lorry	
taxi		bus/coach	
motorbike		Other (please specify)	

IMPORTANT: to complete the in-car drive on public roads, you will need to have one of the following: ***(please indicate the one that applies to you)***		
a) Full driving licence	b) Provisional driving licence	c) Provisional disability assessment licence
d) Section 88	e) I do not have any of the above	
Licence number (if known):		Expiry date: / /
If you do not have a licence or it is about to expire, have you applied or re-applied to the DVLA for a licence? **YES/NO** Please give details: **If this assessment is part of an application for a licence, you may need more than one appointment, for which there will be an additional charge.**		

You will need to bring a paper copy of your driving record on the day of your appointment (https//www.gov.uk/view-driving-licence). If you need assistance with this, please talk to us at the time of booking and have your National Insurance number to hand. Failure to provide this document will mean that we are unable to undertake an assessment on public roads and there will be an additional fee to return to the centre to complete this part of the assessment

Part C. INFORMATION ABOUT YOUR CURRENT DRIVING ACTIVITIES ***(* please delete as appropriate)***
Are you driving now? **YES/NO** (*) Does it have any adaptations? **YES/NO** (*) If **YES**, please specify:
If **YES**, how many miles a week? What is the make and model of your car? Is it Automatic/manual/electric? (*)
If **NO,** when did you last drive? Why have you not driven this time?
What are you hoping to gain from this assessment?
Are there any specific adaptations that you are interested in? **Please note that although we will try to source your request, it may not be possible to do so, and we will utilise equipment that we have available on site.**

Part D. INFORMATION ABOUT YOUR CURRENT DRIVING ACTIVITIES (continued)	
Can you independently transfer into and out of a car?	**YES/NO**
Do you need equipment/assistance transfer? If YES, please give details	**YES/NO**
Are you a wheelchair or electric scooter user? **YES/NO (*)** **MANUAL/ELECTRIC (*)**	
Name/type of wheelchair/scooter: Width of your wheelchair measured from the outside of one wheel to the outside of the other wheel. Please state whether the measurement is in inches or centimeters.	
Can you independently load/unload your wheelchair/scooter into a vehicle?	**YES/NO**
Do you need to drive from a wheelchair?	**YES/NO**

Part E. MEDICAL INFORMATION ***(* please delete as appropriate)***		
1	**Have you ever had a head injury/period of consciousness/brain surgery?**	**YES/NO**
	If YES, please give details:	
2	**Have you ever had fits/seizures?**	**YES/NO**
	If YES, when was the date of your last episode? *We may need to contact you for further information*	
3	**Do you have episodes of fainting? (Other than associated with the sight of blood or disturbing news)**	**YES/NO**
	If YES, when was the date of your last episode?	
4	**Do you have dizziness or vertigo? (Exception as above)**	**YES/NO**
	If YES, when was the date of your last episode?	
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 episode?	**YES/NO**
	If YES, when was the date of your last attack?	
6	**SIGHT: Do you have any vision defect? E.g. double vision or other visual field issues** (other than requiring correction by spectacles)	**YES/NO**
	If YES, please give details:	
7	**HEARING: Do you have any difficulty with your hearing?**	**YES/NO**
	If YES, please give details:	

Part F. LIFESTYLE INFORMATION (*please delete as appropriate) Do you require assistance for: (please give details in the space provided)	
Personal care?	
Domestic tasks?	
Outdoor mobility?	
How has your condition caused you to alter your lifestyle, employment situation or leisure activities?	

Part G. GENERAL PRACTITIONER (GP)/CONSULTANT INFORMATION – only complete this section if: -	
you consent to QEF contacting your GP for further medical information if required **YES/NO**	
you would like a copy of the report to be sent to your GP/Consultant **YES/NO**	
GP/Consultant name: Telephone: Email:	Address: Postcode:

Part H. DECLARATIONS	
I understand that there will be a 25% administration charge for all cancellations if another appointment is not required.	**YES/NO**
I understand that if I fail to attend my appointment, or do not complete the assessment, or if I do not give at least seven days cancellation notice, the fee will not be refunded.	**YES/NO**
I understand that staff may record images during assessments to provide additional content to the written report.	**YES/NO**
I understand that the assessment may involve some manual handling to enable me to access any relevant equipment, such as the static rig unit or into a car.	**YES/NO**
I understand I have the right to withdraw from the assessment at any time.	**YES/NO**

If there is a power of attorney (POA) in place or a court appointed deputy, please attach a copy of the document.

I, (client name **or** POA), ... declare that the above document is accurate to the best of my knowledge.

Signed: ..... Date: .....

Part I. SELF REFERRAL FEE STRUCTURE (i.e. not DVLA or Motability referrals)	
Full cost of an assessment for a CAR/TAXI	**£375**
LORRY/BUS/COACH/MOTORBIKE	**£710 (includes off-site costs)**
HI-TECH (longer appointment)	**£540**

Please note, that if payment is made by a 3rd party organisation (e.g., solicitor, case manager), then VAT will be applied to the above fee at the standard rate

Payment can be made by credit or debit card or cheque. If payment is to be made by BACS (please ask for details).

Part J. PAYMENT INFORMATION	
Is someone else paying?	YES/NO
If YES, is the payer family or friend? **Or** Organisation or Health Care Professional (HCP) *	YES/NO YES/NO
Do you require an invoice? **£72+VAT surcharge**	YES/NO
Please provide the full contact details of the payer (if not the client detailed in Part A) Name: Address: Postcode: Telephone: Email:	

(*) Self-referral with 3rd party organisation/HCP paying. Please note the following:

1. Our contract is with the client or their POA/Court Appointed Deputy, and we will not discuss any aspect of the assessment process with another organisation or their representative. If you wish us to liaise with a 3rd party, then do not submit this application form. Please advise the 3rd party/organisation to request/complete the 3rd party application form available on our website or from the office.

2. The assessment report (one copy only) goes to the client and the GP/Consultant if indicated above in Part G. It is the responsibility of the client to provide copies of this report to other 3rd parties or organisations.

OFFICE USE ONLY **Amount paid: …… REF: ……**

Consent to speak to a family member/friend

If you are over the age of 13, and you would like a family member/friend to act or speak on your behalf, please complete details below:

Individual 1

Name: .....Relationship to client:.....

Address:.....

.....Postcode.....

Mobile: .....Email: .....

Please indicate when you would like QEF to contact the person named above:-

To make appointments on my behalf	YES ☐	NO ☐
To discuss progress, recommendations and outcomes	YES ☐	NO ☐
To make payments	YES ☐	NO ☐

Individual 2

Name: .....Relationship to client:.....

Address:.....

.....Postcode.....

Mobile: .....Email: .....

Please indicate when you would like QEF to contact the person named above:-

To make appointments on my behalf	YES ☐	NO ☐
To discuss progress, recommendations and outcomes	YES ☐	NO ☐
To make payments	YES ☐	NO ☐

Signature:.....Name:.....Date:.....

If you want to change your decision at any time in the future, please let us know in writing.

EQUAL OPPORTUNITIES DATA

We are obliged to ask this information from the organisations that fund our service.
You do not have to answer these questions, and if you choose not to, this will not make any difference to the service you receive.

Ethnic Origin:

Asian Bangladeshi ( ) Asian Indian ( ) Asian Other ( ) Asian Pakistani ( )

Black African ( ) Black Caribbean ( ) Black Other ( ) Chinese ( )

Mixed Other ( ) Mixed White + Asian ( ) Mixed White + Black African

Mixed ( ) Mixed White + Black Caribbean ( )

White British ( ) White Irish ( ) White Other ( )

Ethnic Other ( ) Please specify_____

Declined to comment ( )