**DRIVING ASSESSMENT REFERRAL FORM**

**Please complete all sections:**

Name: Designation:

Dept & full address:

 Tel:

**Referrer:**

Yes / No No

Has your patient given consent for this referral?

 Yes / No / Unknown

Does the patient meet DVLA guidelines for fitness to drive?

 Yes / No

Do they have a full valid UK driving licence?

**Patient’s Name**: DOB:

Address:

Tel: Mob:

Confirmed Diagnosis:

Reason for referral:

If required, please **continue overleaf** with more information, including any cognitive test results.

Referral for*: (please insert “X” for one of the following)*

* Full Driving Ability Assessment No fee

* Adaptations only No fee

Signature Date

Please email to: info@rdac.co.uk , fax to 0121 333 4568 or post to the above address