**\*\*\*\*TO BE COMPLETED ONLY IF YOU ANSWER ‘YES’ TO QUESTION 7\*\*\*\***

****

**REFUSAL OF A DRIVING LICENCE (FITNESS TO DRIVE)**

NEW / RENEWAL

Our Ref: Disabled Persons Freedom Pass

**Subject: Freedom Pass Application for (Applicant please complete your details )**

Name:

Address:

Date of birth:

***INFORMATION FOR MEDICAL PROFESSIONAL COMPLETING THE FORM***

The above named applicant has applied for the disabled persons Freedom Pass and has indicated that they have a medical condition that would deem them unfit to drive. Please note, this is **not** to be used for Learning Disabilities or Autism/ADHD.

We need to establish if the client is medically fit enough to drive in regards to their medical condition(s).

**The fact that they may not hold a driving licence or cannot drive is immaterial. We just need to establish that they would be a danger to themselves or others if they were to be driving.**

We would therefore be grateful if you could in your professional opinion supply us with the necessary information. Information can be located on the Department for Transport website; The relevant chapter of the *DVLA’s For Medical Practitioner’s At a Glance Guide to the current Medical Standards of Fitness to Drive* based on the information the client has already provided about their condition, which you may find helpful.

***“Would, if he/she applied for the grant of a licence to drive a motor vehicle under part III of the Road Traffic Act 1988, have their application refused pursuant to section 92 of the act (physical fitness) otherwise than on the ground of persistent drug or alcohol abuse.”***

1. Please confirm all diagnosed conditions:

2. Would the client be refused a licence to drive in view of their medical condition?  
Yes No

3. Has your decision been made based on the DVLA Medical Standards of Fitness to Drive?  
Yes No

4. Which section(s) of the DVLA standards does the client fall under?

Psychiatric Disorder Neurological Disorder (which does not affect mobility)

Diabetes Mellitus Visual Disorder Drug/ Alcohol Misuse & Dependence

**The fact that they may not hold a driving licence or cannot drive is immaterial. We just need to establish that they would be a danger to themselves or others if they were to be driving.**

5. If you patient holds a driving licence, have you advised the client/patient of your recommendations for the cessation of driving? **YES / NO**

If not please confirm why the client has not been informed.

6. Give the approximate date of diagnosis of the condition(s):

7. Describe how the condition would affect the client when driving and generally:

8. Please confirm the treatment, the medication and dosage prescribed:

|  |  |  |
| --- | --- | --- |
| **Name of Medication** | **Dosage** | **Reason for prescribing** |
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9, What would be the side effects of this medication?

10. Would appropriate treatment and medication control the client’s condition enabling them to drive in the future? **YES / NO**

If yes when would it be likely that satisfactory control of the symptoms would be attained to enable driving?

11. Are the symptom(s) of the client’s condition(s) that prevent the client from driving intermittent, for example seizures? If yes please confirm when the last known episode occurred and how frequently episodes have arisen in the past 12 months:

12. Have you recommended a review date regarding either client’s condition or driving?  
Yes, please specify when

No

Consultant Psychiatrist or

Doctor's signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Team/Practice Location\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*PRACTICE STAMP*

**Practice Stamp:**

**The practice stamp will**

**Validate the signature**.

Please note that any Invoices submitted with this document will be authorised by Inspire, then forwarded to the CCG for payment.

Please return this document along with any invoice to:

**Freedom Pass Team, Inspire Living Solutions, 50 High Street, Sidcup, Kent, DA14 6EH**

Thank you for your assistance.

Finally, please do not hesitate to contact us either by telephone 01322 520560, option 7 , or email travelawards@inspirecommunitytrust.org.

Yours sincerely

Nicola Francis

Freedom Pass Service Coordinator