

**MOTORCYCLE
 ASSESSMENT APPLICATION FORM**

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 ()

Medical History:.....

.....

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

£..... Motorcycle Assessment
(for those with neurological damage, e.g. Cerebral Palsy, Stroke, Head Injury, Spina Bifida/Hydrocephalus, Dementia/ Memory loss/ Frail/ Elderly/ Compromised immune system etc)

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

IF YOU HAVE HELD A FULL LICENCE

Licence number (if known) Expiry Date

Number of years' driving experience?

PLEASE BRING YOUR LICENCE WITH YOU

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- b) Your licence has been revoked []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/riding []
- 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 []

Current Vehicle 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?.....

If NO, when did you last drive?.....

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.....

.....

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.....

.....

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 a list with you**

.....

.....

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

If YES, please state

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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)

Can you independently transfer onto and off a bike? YES / NO

DECLARATION

I give my consent for QEF Mobility Services 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: