Irish Wheelchair Association™

Motoring Advice, Assessment and Tuition Services
Client Application Form

Section 1: To be completed by Applicant

Section 2: To be completed by Medical Professional

NOTE: The fee for a driving assessment is €170. Payment will be accepted on the day of the assessment. Completed forms should be returned to:

Irish Wheelchair Association, MAATS Section, Clane, Co Kildare.
Tel: 045 893 094 or Email: maats.admin@iwa.ie

Section 1: To be completed by Applicant

Personal Details

First Name:		Surname:	
Gender		DOB:	
Address:		Postal Code:	
Contact No:		Email:	
Next of Kin:		Relationship to Client:	
Contact No:			

Reason for Driving Assessment:

How does your disability/medical condition impact on your ability to drive?
(Please give as much information as possible, eg. Use of limbs, restricted movement, strength, tiredness, co-ordination etc).

If applicable, please outline what driving elements are difficult:
(eg. Use of brakes, accelerator, clutch, steering, vehicle access, etc).

Have you undergone a Driving Assessment previously?

Yes or No?	

If yes, please give further information

Irish Wheelchair Association

Motoring Advice, Assessment and Tuition Services

Client Application Form

Driving Status: Please note: IWA cannot accept clients for a driving assessment unless you hold a current learner permit or full driving licence. If your learner permit or full licence is out of date, please contact your GP/Consultant.				
Current Licence Status:	Learner Permit:		Full:	
Type of car currently driving:	Manual:		Automatic:	
Licence/Learner Permit:	Issue Date:		Expiry Date:	
Are you currently driving?	Yes:		No:	
If no, please confirm date last driven				
How long have you been driving?				
Have you had any accidents or incidents in the last five years?	Yes:		No:	
If yes, please provide details:				

Please tick your preferred choice of centre for the assessment:							
Clane		Clontarf		Carrick on Shannon		Galway	
Kilkenny		Letterkenny		Limerick		Mullingar	
Navan		Wexford					

Are you willing to authorise the IWA driving assessment team to contact other medical professionals or driving assessors to assist in your driving assessment.			
Yes:		No:	
Client Signature:		Date:	

If signing on behalf of the applicant please print your name in block capitals below:

Data Protection

How information about you will be used: IWA respects the privacy of applicants. IWA will hold information in a secure manner. Only authorised IWA personnel will have access to this data and may contact you from time to time based on areas of interest and communications preferences indicated by you.

Using your information: We may use your information in assisting IWA: n To understand your requirements n To improve and develop services n To advocate on behalf of People with Physical disabilities to Government Departments.

We do not disclose any personal details or information without your authorisation.

Contact: A copy of IWA's Data Protection Policy is available from IWA's Customer Care Department.
If you require any further information you can email: customercare@iwa.ie or call 01 818 6455

Consent: By submitting this form, you are consenting to IWA collecting and processing your personal data for the purposes outlined.

Section 2: To be completed by Medical Professional

Medical Background				
Primary Diagnosis:				
Date of Diagnosis/Occurrence:				
Any Secondary Conditions:				
Has the client had seizures in the past 12 months?	Yes:		No:	
If yes, please provide information:				
Is the client currently taking any medications that may impact on their ability to drive?	Yes:		No:	
If yes, please provide information:				

Vision				
Does the client meet the visual requirements for driving?				
Visual Acuity?	Yes:		No:	
Visual Fields?	Yes:		No:	
Note: Please refer client for a full visual investigation to specialist eg. (Ophthalmologist, Orthoptist or Optometrist) if you have concerns about his/her vision for driving.				

Cognitive Status:				
Does the client have any cognitive issues?	Yes:		No:	
If yes, please provide details (cognitive,visual/perception):				
(Please include where applicable copy of any cognitive assessments results/hospital discharge reports).				

Physical Status:				
Does the client have any upper limb difficulties that may impact on driving ability?				
Does the client have any lower limb difficulties that may impact on driving ability?				
Is the client medically fit to participate in a full driving assessment including an on-road test?	Yes:		No:	
Please list all other services/agencies involved in client's care (where applicable).				

GP Details	
GP Name:	
GP Address:	
Tel No:	
How long is this patient attending your practice?	
GP SIGNATURE AND STAMP:	
Date:	

3525 MT