Community Stroke Team

Wythenshawe Offices

1 Stancliffe Road

Manchester M22 4PJ

Tel- 0161 529 6777

*Information regarding Driving after Stroke*

As part of your Stroke Rehabilitation, we wish to identify whether you have any problems as a result of your stroke, which may affect your ability to drive a car.

Some people have problems with concentration, reasoning and their interpretation of the things they see after a stroke. These may affect their driving ability.

The assessment we offer is a screen only, which would indicate whether or not you may require further assessments. This is not a screen of your physical ability to drive.

The screen gives an indication about your cognitive function and will enable us to make an informed decision. If we identify any issues, we can offer another screen in a further 6 weeks. If during the second assessment some of the issues are persistent then we may also refer you to the Regional Driving Assessment Centre (RDAC) for further on-road assessments.

**DVLA guidance after stroke for Car or motorcycle licence users states-**

You must stop driving for at least 1 month. You can restart only when your doctor or healthcare professional tells you it is safe. You do not need to tell DVLA if you had a stroke and have recovered.

You must tell DVLA if you still have any of the following after 1 month:

* weakness in your arms or legs
* problems with your eyesight – for example visual field loss or double vision
* problems with balance, memory or understanding

You must also tell DVLA if:

* you have had any type of seizure
* you needed brain surgery as part of your stroke treatment
* your doctor thinks you may not be safe to drive

The guidance can be found on- [Stroke (cerebrovascular accident) and driving - GOV.UK](Stroke%20%28cerebrovascular%20accident%29%20and%20driving%20-%20GOV.UK) or https://www.gov.uk/stroke-and-driving

**Consent**

I consent to completing these screens and am happy to comply with the advice from the Occupational Therapist from the community stroke team.

Patient’s name: ..………………………………………………………..

Patient’s signature: …………………………………………………….

Date: …………………………………….

Contact details-