CHAPTER 6  ADVISING THE OLDER ADULT ABOUT TRANSITIONING FROM DRIVING

Key Points

• Health care providers should proactively/annually screen frail older adults for driving safety and consider referral for comprehensive driving evaluation by a driving rehabilitation specialist/occupational therapist.
• Health professionals should encourage discussion of a driving retirement plan prior to the patient losing their privilege to drive.
• When an older adult is unsafe to drive, they and their caregivers should review the assessment and conclusions and discuss alternative transportation options; this should be documented in the older adult’s health record.
• If an older adult who is unsafe to drive continues driving, caregiver responsibility and intervention (when available) is important to document. A “do not drive” prescription that is provided to the older driver and if appropriate, the caregiver, should be considered if the patient is medically unfit to drive. The clinician should also consider, sending a formal letter to the older adult recommending driving cessation and notifying the State licensing agency.
• Clinicians should know referral sources in the community that can provide mobility counseling and information on local transportation alternatives such as gerontological care managers, social workers CDRS’s, and local Agencies on Aging.

Mr. Phillips returns for a follow-up visit after undergoing driver assessment. The driver rehabilitation specialist (DRS) recommended that wide-angle rearview mirrors be fitted on Mr. Phillips’ car. Mr. Phillips states that he is driving more comfortably with this adaptive device. You counsel him on the Tips for Safe Driving and Ten Tips for Aging Well, advise him to continue walking, and encourage him to start planning alternative transportation options. His daughter is recruited to assist Mr. Phillips and his son with these discussions and interventions.

You continue to provide care for Mr. Phillips’ chronic conditions and follow up on his driving safety. Three years later, Mr. Phillips has a right middle cerebral artery stroke and deficits of left-sided weakness and hemispatial inattention. His health has declined to the extent that you believe it is no longer safe for him to drive. You also feel that because of the fixed nature of his deficits (longer than 6 months since the event), driver rehabilitation is unlikely to improve his driving safety. Mr. Phillips has decreased his driving over the years, and you now tell him that it is time to stop driving completely. Mr. Phillips replies, “We’ve talked about this before, and I figured it was coming sooner or later.” He believes that rides from family and friends and the senior citizen shuttle in his community will be adequate for his transportation needs, and he plans to give his car to his granddaughter.
For most of us, driving is a symbol of independence and a source of self-esteem. When we retire from driving, we lose not only a form of transportation but also all the emotional and social benefits derived from driving. In primary preventive care, the transition to cessation of driving may be discussed during the Medicare Annual Wellness Visit. The Medicare Learning Network (detailed on www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AWV_chart_ICN905706.pdf) provides educational products and information to proactively address health conditions that may adversely affect driving ability.

Advance planning for driving cessation ideally will be reviewed along with other standard instrumental activities of daily living in primary prevention. In secondary prevention, referral to the clinical team can assist with anticipation of and preparation for driving cessation1, rather than responding abruptly in an acute need.

For various reasons, clinical team members may be reluctant to discuss driving cessation with older adults. Clinicians may fear delivering bad news or be concerned that the older adult will lose mobility and all its benefits. Clinicians may also avoid discussions of driving altogether, because they believe that an individual will not heed their advice or become angry. Clinicians may be concerned about losing an individual to another practice.

These concerns are all valid. However, clinical team members have an ethical responsibility to protect the safety of the older adult, as well as that of the public, through assessing driving-related functions, exploring medical and rehabilitation options to improve driving safety, and when all other options have been exhausted, providing recommendations for restriction or cessation of driving. Within the clinical team, the physician is often considered key for driver licensing and assessment referral. The development of a universal State licensing agency fitness-to-drive form would assist with clear, objective medical documentation,2 along with consistent guidelines across States.

In tertiary preventive care, when it is clear to the clinical team that an older adult driver must stop driving, the team must manage such challenging cases, including encouraging the older adult driver to involve caregivers in creating a transportation plan and obtaining the older adult driver’s permission when involving his or her support system.

**Useful Steps in Counseling Older Adults to Stop Driving**

**Begin with the older adult’s perspective**

An initial assessment of the older adult’s perception of his or her driving ability often directly impacts the process in which a person redefines not only personal mobility but also public risk. Reviewing the self-perceived driving skills of the older adult is critical in any discussion regarding driving cessation. Interviews of older adult drivers demonstrate the critical attitudes combined with social pressure impacting driving conduct.3 The older adult’s individual epiphany, self-determination, confidence, autonomy, and relatedness to social
activity require understanding by the clinical team.

When drivers 65 and older were studied regarding when they would terminate driving, responses were extremely varied. Responses included the following: cessation at a definite age (half stated during their 90s), at the onset of vision decline, at no time would they terminate driving (1 in 10), or cessation when they believed they became a hazard on the road.4

Assess family/caregiver readiness for mobility transition.

Whenever available, there is no substitute for caregiver support in developing plans for driving cessation. It is important early on to determine whether or not the older adult has any caregivers who can support their transition. Caregivers often wish the clinical team would intervene and recommend driving cessation for the older adult.5 For a planned transition from driving by the clinical team to be successful, the caregivers’ buy-in to a unified position and support is critical. It is very difficult to successfully counsel older adults to stop driving if their caregivers wish them to continue operating a motor vehicle or disagree among themselves.

Remember that if there is an involved caregiver, they are the one constant and consistent member of the “team.” Education of the caregivers may increase informed decision-making and prevent plan-of-care errors.6 When no caregiver support is available, it is very important to engage local resources through community agencies such as Area Agencies on Aging to provide additional services.

Utilize a clinical team.

Clinical teams require skill sets, assessment instruments, and an appreciation of age-related driving retirement challenges. Because driving cessation involves so many aspects of the older adult’s coping style and physical and mental health, the availability of social support and a clinical team sensitive to age-related mobility change is critical to address multiple needs and direct an intervention plan.7

Develop clinical team communication.

Clinical teams concur that concise communication is both fundamental and one of the most challenging aspects of good care during a transition process. Cultural heritage must be acknowledged and respected in decision making, because a lack of understanding may prevent the older adult from requesting clarification. Older adults with compromised health literacy may agree with the clinician in an effort to maintain their dignity, even when they do not fully understand medical terminology.8

Explain the Importance of Driving Cessation

If the older adult driver has undergone the CADReS toolbox assessments (see Chapters 3 and 4) or assessment by a driver rehabilitation specialist, results in simple language should be provided to the older adult driver and his or her caregivers to share and discuss. Results
should be clearly explained, including what they indicate about the older adult driver’s level of function and why this function is important for driving. The potential risks of driving should be stated, ending with the recommendation that the older adult stop driving. This might be a good time to discuss the older adult driver’s thoughts or feelings, especially if he or she were to cause a vehicle crash. If the older adult should not drive, you might discuss issues related to injury, public safety, and/or financial liability. This discussion should be put in writing with copies given to the older adult driver. If the older driver lacks decision-making capacity, a copy should be given to a family member or caregiver.

“Mr. Phillips, the results of your eye exam show that your vision isn’t as good as it used to be. Good vision is important for driving because you need to be able to see the road, other cars, pedestrians, and traffic signs. With your reduced vision and now that you’ve had a stroke, I’m concerned you’ll be in a car crash. Because your visual deficits from your stroke cannot be corrected to a level safe for driving, for your own safety and the safety of others, it’s time for you to retire from driving. In addition, there are legal requirements for vision that, unfortunately, you no longer meet.”

Older adult drivers may become upset or angry at the clinical team’s recommendation to curtail driving. These feelings should be acknowledged, and although clinicians should be sensitive to the practical and emotional implications of driving cessation, it is necessary to remain firm with the recommendation. Engaging in disputes or long explanations should be avoided. Instead, the focus should be on making certain the older adult understands the recommendation and that it was made for his or her safety. If the older adult driver is mentally competent and willing to allow a caregiver to be present at the visit, this may be helpful when communicating this sensitive information. All discussions should be documented in the health record. It is critical for the clinical team to reinforce, reinterpret, and follow up with the older adult driver and caregiver during this transition.

**Discuss Transportation Options**

Once a driving cessation has been recommended, possible transportation alternatives need to be explored and discussed with the older adult. Unfortunately, driving cessation has been associated with a decrease in social engagement, depression, anxiety, and long-term care placement. Older adults should be encouraged to take control of their future by creating a transportation plan. (If the individual does not have the cognitive capability for these tasks, see the section on those who lack decision-making capacity later in this chapter.)

Providing the older adult resources to explore options (e.g., handouts in Appendix B) will help empower him or her to formulate a personal plan for transportation. Special mention is made of The Hartford’s (The Hartford Center for Mature Market Excellence) educational...

Using alternative transportation options, such as buses, trains, cabs, or even walking, offers older adults independence from having to rely on others. However, these may not be reasonable alternatives for those with physical frailty and/or dementia. It may be useful to use the Beverly Foundation’s dementia friendliness calculator (based on the 5 A’s of transportation: availability, acceptability, accessibility, adaptability and affordability) when searching for services.

A discussion of driving alternatives can begin by asking if the older adult has made plans to stop driving or how he or she currently finds rides when driving is not an option. Alternative transportation methods (Table 6.1) should be explored, as well as any barriers the older adult foresees (e.g., financial constraints, limited service and destinations, required physical skills for accessibility).

The older adult may need assistance to identify his or her most feasible transportation options, because certain cognitive and physical skills are often necessary to use particular transportation alternatives. The importance of planning ahead for social activities, which contribute to quality of life, should be stressed. Older adults in driving retirement should be encouraged to contact the Area Agency on Aging and/or Alzheimer’s Association for information on local resources such as taxis, public transportation services, and senior-specific transportation services. For connection to senior services nationwide, The Eldercare Locator (800-677-1116 or at [www.eldercare.gov](http://www.eldercare.gov/); be prepared to provide the relevant city and State) can provide connections to senior services nationwide. This might be a good time to refer to clinical teams, including a social worker, nurse, or a gerontologic care manager. The team may be aware of alternative modes of transportation and/or may deal with the older adult’s feelings of social isolation or depression.

Older adults should be encouraged to involve caregivers and supportive friends and to form a team in creating a transportation plan. The older adult’s permission should always be obtained when involving others, who should be encouraged to offer rides and formulate a weekly schedule for running errands. However, the older adult should not be ignored when caregivers are included in the discussion. Help in arranging for delivery of prescriptions, newspapers, groceries, and other services may also be considered (see Table 6.2).

**Reinforce Driving Cessation**

When the message to cease driving is essential for ensuring the older adult’s safety, this also places a significant demand on the adult to change his or her current behavior. Therefore, the
clinical team will need to ensure the older adult understands the reasons (legal, health, and safety) for the driving cessation recommendation. In many cases, older adults may become argumentative or emotional during the office visit. They may not fully comprehend the recommendations or remember all the information provided. Messages can be reinforced by the following:

- **Make open-ended statements**, such as “Please share with me your concerns regarding the assessment and recommendations.” Reassure the older adult that you and the clinical team are available if he or she has questions or needs further assistance.
- **Use a teach-back technique** by requesting the older adult to repeat why he or she must not drive. Stress that this recommendation is for his or her personal safety and the safety of others on the road.
- **The older adult driver may benefit from visual reinforcement** of a prescription with the words “Do Not Drive.” Ensuring that the older adult understands why he or she is receiving this prescription may help avoid feelings of anxiety or anger. See Table 6.3 for further reinforcement tips.
- **Send the older adult a letter** that recommends driving cessation (see Table 6.6 for a template). Place a copy of this letter in the health record as both documentation and another visual tool for reinforcement. The letter should be written in simple language to ensure the older adult understands the clinical team’s recommendation.
- **The clinical team must understand each State’s reporting requirements** and explain this requirement to the older adult driver and caregivers (see Chapters 7 and 8 for more details). State regulations, in the case of mandatory reporting laws, dictate that older adult drivers and possibly by proxy, their caregivers, must inform the local State licensing agency of medical conditions that could affect the older adult’s safe operation of a vehicle. The older adult should be informed that the State licensing agency will follow up and what to expect as part of this evaluation (i.e., a review of the driving record, a medical statement, potentially on-road testing).
- **In States with voluntary laws**, a referral to the licensing agency could still be appropriate, and older adults may be informed that they will be reported, if they drive against medical advice.
- **Help facilitate caregiver assistance in encouraging driving cessation**, and if necessary, encourage the older adult to self-report his or her impairment to the State licensing agency. It may be helpful to enlist other trusted allies, such as clergy, friends, or the family attorney.
- **Request the older adult driver return in 1 month** for a follow-up assessment (see next section).
Follow-Up with the Older Adult

At the older adult’s follow-up appointment, clinicians should assess:

- The older adult’s ability to comply with the driving cessation recommendation
- Transportation resources the older adult identified and has or has not used, evaluating the viability of the chosen options
- Signs of isolation or depression

The assessment should begin by asking the older adult how he or she got to the appointment that day. This will help determine whether the older adult has been able to plan for and schedule transportation to and from necessary appointments. Ensure that the older adult has secured reliable and sufficient transportation resources to meet his or her needs.

Utilize the clinical team; refer to a social worker or gerontologic care manager.

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**Clinician:** I’m pleased to see you for your follow-up appointment today. How were you able to get to the office?

**Mr. Phillips:** Oh, my son dropped me off.

**Clinician:** I see. Has he been driving you lately?

**Mr. Phillips:** Yes, ever since I stopped driving, he and his wife have been taking me where I need to go. He’s going to pick me up in 15 minutes.

**Clinician:** How has that been working for you?

**Mr. Phillips:** It’s worked quite well.

**Clinician:** I have a prescription for you to refill your medicines after our appointment. Will your son be able to take you to the pharmacy?

**Mr. Phillips:** Yes, that won’t be a problem.

**Clinician:** It’s wonderful that your son and daughter-in-law are a reliable source of rides for you. What do you do when they are unable to drive you where you need to go?

**Mr. Phillips:** I am stuck at home.

Frailty symptoms (weakness, slow gait speed) combined with depression yield the consequence of higher mortality in older adults. In all levels of care, clinicians should be alert to signs of depression, neglect, and social isolation (see Tables 6.4 and 6.5). It is important to continue to monitor older adults for any signs of worsening mental or physical health and to ask how they are managing without driving. Caregivers should be educated on signs of depression and asked if they have any concerns. Clinicians should consider using formal
assessments for depression such as the Geriatric Depression Scale or the PHQ-9.

The older adult’s functional or cognitive impairments should continue to be assessed and treated. If the older adult improves to the extent that he or she is safe to drive again, the individual should be notified and given the resource sheet on *Tips for Safe Driving* (see Appendix B).

**Situations That Require Additional Counseling**

Additional counseling may be needed to encourage driving retirement or to help older adults cope with this loss. Potential situations that may arise with individuals who have difficulty coping or adhering to the recommendation to stop driving are described below.

**The Resistant Older Adult Driver**

If the older adult becomes belligerent or refuses to stop driving, it is important to understand why. Knowing the reason will help to address the individual’s concerns.

Be sure to listen and use supportive statements when addressing the older adult’s concerns. Let the individual know you are an advocate for his or her health and safety.

Remember that driving cessation can have severe emotional and practical implications, and older adults may have a difficult time adjusting.

Asking the older adult driver to define when a person would be unfit to drive may help the individual better recognize impairment in his or her own driving capabilities, as well as provide an opportunity to assess his or her judgment and insight. In addition, it might open up discussion to reach some common ground.

Many older adult drivers are able to identify peers whose driving they consider unsafe, yet may not have the insight to recognize their own unsafe driving habits. It can be helpful to ask older adults if they have friends with whom they are afraid to drive and why.

It’s important to encourage older adult drivers to begin to think about what to expect when their driving abilities begin to decline and to let them know that many people make the decision to restrict or stop driving when safety becomes a concern. Older adult drivers should be encouraged to obtain a second opinion if the results were borderline or questionable and they feel additional consultation would be helpful.

- Help the older adult driver identify support systems. Ask him or her to list family members, faith communities, neighbors, etc., who are able and willing to help with transportation. This may help the older adult driver become aware of a supportive network and feel more at ease when searching for alternative transportation. Some communities may now have more affordable transportation than taxis such as Uber and Lyft.
- Assist the older adult driver to consider the positives of this decision—an opportunity to assert control over a limitation. Often, discussion of relinquishing driving privileges tends to focus on the negative aspects of driving cessation, such as “losing independence” or “giving up freedom.” Help the older adult driver view this as a step...
in health promotion and safety for themselves and others. Use phrases such as “it’s time to retire from driving” and point out that older adults can still stay connected by requesting rides from caregivers and using community services. It may be helpful to point out that the older driver has quite likely been giving rides to others throughout their driving career, and they may now allow others to return the favor. Another positive is that expenses will be lower without the financial responsibility of maintaining a vehicle.

- Refer the older adult driver to a social worker or clinical team member. Older adult drivers may need additional help in securing resources and transitioning to a life without driving. Social workers often provide supportive counseling to older adults and caregivers, assess the individual’s psychosocial needs, assist in locating and coordinating community services and transportation, and enable older adults to maintain independence and safety while preserving quality of life. The National Association of Social Workers Register of Clinical Social Workers is a valuable resource for finding local social workers who have met national, verified, professional standards for education, experience, and supervision. Information can be ordered and the online register accessed at www.helpstartshere.org/find-a-social-worker. Local hospitals are another resource for social workers, and referral sources include the Area Agency on Aging or the Alzheimer’s Association.

The Older Adult Driver with Symptoms of Depression

Depression may result from a combination of factors such as diminished health, social isolation, or feelings of loss. An older adult driver suspected of being depressed (see Table 6.4) should have a full assessment to determine the most appropriate treatment. Older adults and caregivers should be educated about symptoms of depression and available treatment options. Referring the older adult to individual or group therapy, and/or to social/recreational activities may be considered. Pharmacologic treatment or referral to a mental health professional may also be appropriate. It is important to acknowledge that the older adult has suffered a loss and recognize that this may be an especially difficult time for him or her.

The Older Adult Driver who Lacks Decision-Making Capacity

When the older adult driver has significant cognitive impairment and/or lacks insight or decision-making capacity (e.g., in certain cases of dementia, stroke, etc.), it is imperative to obtain the help of the caregiver, surrogate decision-maker, or guardian, if available. Caregivers play a crucial role in encouraging the older adult to stop driving and to help the individual find alternatives. Clinicians should inform caregivers that the clinical team will support and assist their efforts in any way possible.

In rare instances, it may be necessary to appoint a legal guardian for the older adult. In turn, the guardian may forfeit the older adult’s car and license on behalf of the individual’s safety. These actions should be taken only as a last resort. From a practical standpoint, hiding,
donating, dismantling, or selling the car may also be useful in these difficult situations.

The Older Adult Driver Shows Signs of Self-Neglect or Neglect

Older adults may be unable to secure resources for themselves and may be isolated, lacking sufficient support from family, friends, or an appointed caregiver. If the older adult does not have the capacity to care for himself or herself, or caregivers are unable to provide adequate care, signs of neglect or self-neglect (see Table 6.5) may be evident.

If neglect or self-neglect is suspected, Adult Protective Services (APS) should be involved. Neglect is the failure of a caregiver to fulfill his or her caregiving responsibilities, whether because of willful neglect or as a result of disability, stress, ignorance, lack of maturity, or lack of resources. Self-neglect is the inability to provide for one’s own essential needs. APS will investigate for neglect, self-neglect, or abuse of the older adult. APS can secure services such as case planning, monitoring, and evaluation, and can arrange for medical, social, economic, legal, housing, law enforcement, and other emergency or supportive services. Contact information for each State office can be obtained by calling the Eldercare Locator at 800-677-1116.

Table 6.1 Transportation Alternatives

- Walking
- Train/subway
- Bus
- Taxi/Uber-like services
- Family and friends
- Community transportation services
- Hospital shuttles
- Medi-car
- Delivery services
- Volunteer drivers (e.g., church, synagogue, temple, mosque, community centers)
- Private for-profit senior care services

Table 6.2 Family/Caregiver Assistance

- Encourage family members and caregivers to promote the health and safety of the older adult by endorsing clinician recommendation and assisting in securing needed transportation.
- Include caregivers in the mobility counseling process.
- Provide resources to caregivers.
- Provide copies of the How to Assist the Older Driver resource sheet (Appendix B).
- Look for signs of caregiver burnout.
• Keep the communication door open to caregivers.
• In the case of cognitive impairment when it is believed the older adult driver does not have decision-making capacity (e.g., lack of insight), communication with a family member or caregiver to reinforce recommendations is imperative.
• Recognize that if family members or caregivers depend on the older adult driver for transportation, the situation may require more time, counseling, and support to meet everyone’s needs.


• AAA Foundation (www.aaafoundation.org/senior-drivers)
The emphasis of the AAA Foundation is the behaviors and safety-related attitudes of drivers 65 and older.

• Alzheimer’s Association (www.alz.org/care/alzheimers-dementia-and-driving.asp)
The Alzheimer’s Association provides links to driving counseling support for caregivers.

• American Occupational Therapy Association (www.aota.org)
Locate an occupational therapists able to conduct driving assessment and locations by ZIP code.

• Family Caregiver Alliance (www.caregiver.org)
This organization supports and sustains the important work of families nationwide caring for loved ones with chronic, disabling health conditions.

• The Health in Aging Foundation (www.HealthinAging.org)
This Foundation was established by the American Geriatrics Society to bring the knowledge of geriatrics health care professional to the public, with a wide range of resources.

• Independent Transportation Network America (www.itnamerica.org/what-we-do/our-services)
A national non-profit transportation system for America’s aging population. The ITN service is membership-based - people 60 and older and visually impaired adults are eligible to join.

• National Association of Area Agencies on Aging (www.n4a.org/about-n4a)
Area Agencies on Aging are a leading aging issues resource and national network.

• National Association of Social Workers (www.socialworkers.org)
Locate a social worker by ZIP code.

• National Center for Senior Transportation (www.seniortransportation.net)
The National Center on Senior Transportation strives to increase transportation options for older adults to support their ability to live independently in their homes and communities throughout the United States. It is administered by Easter Seals Inc. in partnership with the National Association of Area Agencies on Aging.
• **National Highway Traffic Safety Administration**
  (www.nhtsa.gov/Driving-Safety/ Older+Drivers)
  NHTSA’s priorities are to reduce the number of deaths and injuries by getting drivers,
pedestrians, and cyclists to change their behaviors once they are behind the wheel or on the
streets. See “Talking With Older Drivers About Safe Driving.”

• **National Volunteer Transportation Center**
  (www.NationalVolunteerTransportationCenter.org)
  The National Volunteer Transportation Center was created to support existing and emerging
volunteer transportation programs and services across the country.

• **Rides in Sight.** A free Transportation Referral Service (www.ridesinsight.org) or call
toll free –855-607-4337. Assists the individual in finding a transportation program in
the older adult’s area. Can be searched on line or the number will be answered by a
person during business hours.

**Table 6.3 Tips to Reinforce Driving Cessation**

- Give the older adult and caregiver a written prescription that states: “Do Not Drive,
  For Your Safety and the Safety of Others.” This acts as a reminder for the older
adult and also emphasizes the strength of your message.
- Remind the older adult that this recommendation is for his or her safety and for the
  safety of other drivers.
- Ask the older adult driver how he or she might feel if he or she were to get in a crash
  and injure themselves or someone else.
- Point out the economic advantages of not having a car, which will eliminate many
  expenses, including gas, maintenance (oil changes, tires, tune-ups), insurance,
  registration/license fees, financing expenses, and depreciation of the car’s value.
- Have a plan in place that involves caregiver support for alternative transportation.

**Table 6.4 Questions to Assess for Major Depressive Disorder (adapted from DSM-5)**

*These questions are in regard to most of the day or nearly every day and are not related to
another medical illness.*

- Has your mood been sad, empty, or hopeless?
- Have you lost enjoyment in all or most activities?
- Have you noticed any weight changes?
- Have you noticed any changes in sleeping habits or concentration?
- Have you noticed a lack of energy or slower movement?
- Have you noticed feelings of worthlessness or recurrent ideas of death?
**Table 6.5  Signs of Neglect or Self-Neglect in Older Adults**

- An injury that has not been properly treated
- Symptoms of dehydration and/or malnourishment
- Weight loss
- Soiled clothing
- Recurrent falls with or without injuries
- Evidence of inadequate or inappropriate administration of medications
- Spoiled or outdated food in the refrigerator
- Loss of income from difficulty with finances

**Table 6.6  Sample Letter**

December 23, 2016  
Mr. Clayton Phillips  
123 Lincoln Lane  
Sunnydale, XX 55555  

Dear Mr. Phillips:

I am writing to follow-up on your clinic visit of December 1, 2016. You’ll recall we talked about your driving safety. I tested your vision (eyes), strength, movement, and thinking skills, and reviewed your health problems and medicines. I recommended you stop driving because of your poor vision, muscle weakness, and slowed reaction time.

I know that driving is important to you, and I know it is hard to give up. But your safety is more important. To help you get around, your son and your friends have offered to help you. You can also use the special bus in your neighborhood. The handout *How to Assist the Older Driver* (enclosed) has some other ideas we talked about. I am also sending a copy of these materials to your son so that you two can discuss this plan together.

I want to make sure you can still visit your friends and go other places without a car. It is important for you to maintain your connection with the community. Please see me again in one month—we will talk about how this plan is working for you.

**In a State that has mandatory reporting, consider adding:**

As we discussed, the State of _______ requires me to notify the State licensing agency of people who have medical conditions that might affect driving safety. Because I am required by law to do this, I have given your name to the __[State name]__ licensing agency. The licensing agency will send you a letter in a few weeks to discuss your driver’s license.

**In a State that has voluntary reporting, consider adding:**

It is very important that you do not drive, because you are putting yourself and the public at risk. If you continue to drive, I will need to submit your name to the State licensing agency for an evaluation and possible revocation of your license.
Please call my office if you have any questions. I look forward to seeing you next month.

Sincerely,

Physician

Enc:  *How to Assist the Older Driver*

cc:  Your son

*Note:* The sample letter in Table 6.6 has been written at a grade 7 level according to Flesch-Kincaid Readability (12/2014).
References


