

Assessing fitness to drive:

Visual standards and general practitioner responsibilities



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Background

Driving requires complex visuospatial, cognitive and physical abilities, with vision being a key determinant of safety. Progressive eye diseases, diabetes and neurological conditions can impair visual acuity (VA) and visual fields (VF), increasing motor vehicle accident risk. With an ageing population, vision-related driving impairment is expected to rise.

Objective

This article summarises Australian driving standard guidelines and provides a practical framework for general practitioners to assess, monitor and refer drivers with visual conditions that may affect fitness to drive.

Discussion

VA and VF primarily determine visual fitness to drive, with specific thresholds for private and commercial licences. Understanding variable state-based reporting laws and initiating early, well-documented conversations about driving retirement can help maintain driver safety and autonomy while supporting community wellbeing.

DRIVING IS A COMPLEX VISUOSPATIAL TASK

that relies on multiple physical and cognitive domains including motor coordination, attention, reactive time and sensory function. Among these, adequate central and peripheral vision is essential to detect hazards, read signs and respond rapidly to environmental changes. Despite this, vision is often an overlooked component of driving assessment. Vision can be affected by a broad range of progressive age-related eye diseases, diabetes and neurological conditions. Further, with Australia's ageing population, the number of drivers at risk of vision-related impairment is expected to rise significantly. The proportion of Australians aged 85 years and older has already increased from 0.5% in 1970 to 2.1% in 2020 and is projected to reach 3.6–4.4% by 2066.¹ With this demographic shift comes an expected increase in age-related eye diseases such as glaucoma, age-related macular degeneration (AMD) and cataracts, all of which can affect driving safety. Drivers with AMD or glaucoma are more likely to make critical driving errors when compared with those without eye disease.^{2,3} Even mild or self-reported visual impairment has been linked with reduced driving performance.⁴ General practitioners (GPs) are often the first point of contact for drivers with visual concerns and play a key part in screening, referral, advising on driving

safety and liaising with driver licensing authorities (DLAs). Understanding the visual standards for licensing is therefore essential in supporting safe driving while maintaining driver independence.

The aim of this article is to summarise driving standard guidelines and provide a guide for GPs to identify, monitor and refer drivers with visual conditions that may affect fitness to drive.

Which visual parameters determine fitness to drive?

There are two main visual measures that determine fitness to drive (Table 1). These are visual acuity (VA) and visual fields (VF).⁵

VA can be measured with a standard Snellen or logarithm of minimum angle of resolution (logMAR) chart positioned 6 m from the driver, or 3 m using a mirror. The Snellen chart expresses VA as a fraction (eg 6/12) but has irregular spacing between letters and lines, making it less precise for detecting small changes. In contrast, the logMAR chart uses equal letter spacing and consistent size progression, providing a more accurate and reproducible measure of VA. Two or more errors in reading the letters of any line is considered a failure of that line. Each eye should be tested separately without (uncorrected VA) or with (corrected VA)

Table 1. Visual acuity and visual field standards⁵

Group	Licence type	Private standard	Commercial standard
Visual acuity	Unconditional	At least 6/12 in one eye or both eyes together	At least 6/9 in the better eye At least 6/18 in the worse eye
	Conditional	At least 6/12 in one eye or both together with corrective lenses Or Following optometrist/ophthalmologist review, better eye must be at least 6/24	At least 6/9 in the better eye At least 6/18 in the worse eye with corrective lenses
Visual fields	Unconditional	At least 110° horizontal field within 10° above and below the horizontal midline Not have any significant scotoma within a central radius of 20 degrees from fixation Not have any other scotoma likely to impede driving performance	At least 140° horizontal field within 10° above and below the horizontal midline Must not have any visual field defect
	Conditional	Horizontal field between 110° and 90°	At least 140° horizontal field within 10° above and below the horizontal midline No significant visual field loss (scotoma, hemianopia, quadrantanopia) The visual field loss is static and unlikely to progress rapidly

corrective lenses. If spectacles, contact lenses or orthokeratology lenses are required to meet criteria, then the individual requires a conditional licence with corrective lenses.

Aside from VA, VF are also important for driving, especially for detecting traffic signals, parked cars and pedestrians. VF refers to the total area a person can see while looking straight ahead, encompassing central and peripheral vision. In general practice, VF may be screened in those without any clinical indication of a VF impairment through confrontation. For those who require more detailed assessment based on screening or on their medical condition, fields may be assessed with a Humphrey Visual Field Analyser (monocular test) or an Esterman visual field test (binocular test). The horizontal extent of a normal binocular VF is 200 degrees, with the central 120 degrees overlapping for stereopsis. Furthermore, each eye has 75 degrees of field inferiorly and 60 degrees superiorly.⁶ For drivers undertaking a binocular Esterman, the false-positive score must not be more than 20%.⁶ Importantly, both techniques require fixation, where the driver keeps their eyes focused on a central target while responding to peripheral stimuli. In drivers

who cannot reliably fixate, a modified roving Esterman test may be used. This does not require fixation on a central point. Instead, the stimuli are presented across the VF while the driver moves their gaze. As it is less precise, the roving Esterman must be conducted twice, with only one false positive allowed. This additional form of VF testing is typically performed by an ophthalmologist or, in some settings, by optometrists with appropriate equipment and training.

What are the VA and VF standards for each licence?

Both VA and VF standards differ according to the type of licence. Private standards apply to those holding a licence for a motorcycle, car or light rigid vehicle (4.5–8 tonnes gross vehicular mass [GVM] plus a trailer of up to 9 tonnes). Commercial standards apply to vehicles greater than 8 tonnes GVM including medium rigid, heavy rigid, heavy combination or multiple combination vehicles. Commercial standards include drivers carrying passengers for reward or hire (eg bus drivers, chauffeurs).⁷

For either private or commercial licences, these may be unconditional or conditional.

The latter involve specific restrictions or requirements placed on the driver. Restrictions may include driving only in local areas or no night driving. Examples of requirements are: use of corrective lenses, complying with a medical treatment, or certain vehicle modifications.⁸ These licences often require input from optometrists or ophthalmologists and can only be issued by the DLA, which is the government agency responsible for assessing fitness to drive as well as issuing, renewing and regulating driver licences (eg VicRoads in Victoria).

Conditional licences are considered by the DLA and are subject to periodic review.

The binocular Esterman VF results from Jiang et al (2021) show a pass (Figure 1) and fail (Figure 2).⁹ In Figure 1 there is no significant defect within the central 20 degrees of fixation (circle). Meanwhile, in Figure 2 there is a single cluster of three adjoining missed points within 20 degrees from fixation.

Diplopia or monocular vision

Drivers with monocular vision have no depth perception, and a reduced visual field due to the nose obstructing the field. With an acute

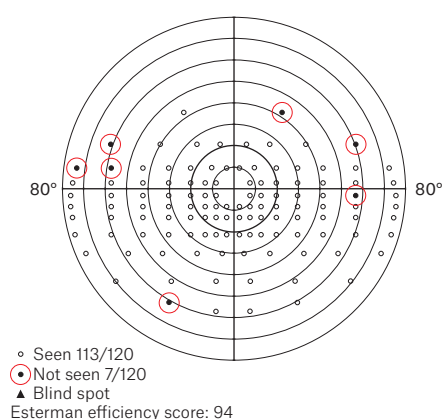


Figure 1. Binocular Esterman with no significant central defect, showing a pass.

Adapted from Jiang ZY, Chen J, Yao J, Qian SH. Impact of binocular visual field loss on driving performance in glaucoma patients. *Int J Ophthalmol* 2021;14(1):112–19. doi: 10.18240/ijo.2021.01.16, licensed under CC BY-NC-ND 4.0 (<https://creativecommons.org/licenses/by-nc-nd/4.0>).

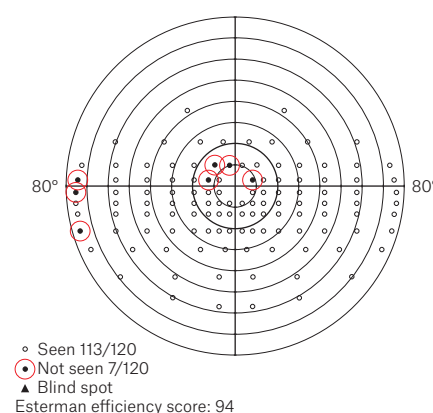


Figure 2. Binocular Esterman with significant central defect, showing a fail.

Adapted from Jiang ZY, Chen J, Yao J, Qian SH. Impact of binocular visual field loss on driving performance in glaucoma patients. *Int J Ophthalmol* 2021;14(1):112–19. doi: 10.18240/ijo.2021.01.16, licensed under CC BY-NC-ND 4.0 (<https://creativecommons.org/licenses/by-nc-nd/4.0>).

loss of vision in one eye, over a 3-month period some depth perception (stereopsis) may be regained as a result of monocular cues and visual adaptation. Drivers may then be eligible for conditional licences (Table 2).⁵

Drivers are not fit to drive if their diplopia affects 20 degrees outside of central fixation. However, they may be suitable for a conditional licence if the diplopia is within 20 degrees from central fixation and they wear an occluder (eg an eye patch or opaque lens to eliminate diplopia through monocular occlusion). Similar to monocular vision, after any acute diplopia, a 3-month period of non-driving should occur to allow adaptation to monocular cues.

Visual inattention and hemi-spatial neglect

Following an acquired brain injury, particularly a right (non-dominant) parietal stroke, deficits in spatial attention may significantly impair driving safety. Although not listed as a discrete visual disorder in *Assessing fitness to drive*, hemi-spatial neglect affects safe driving through impaired visuospatial perception, attention, insight and judgement. Under Austroads private licence standards, drivers should avoid driving for at least 4 weeks after a stroke, and they should only resume driving if residual symptoms

do not cause significant impairment in these domains.¹⁰ On screening, confrontational fields may appear normal when tested in isolation, but deficits may be revealed with bilateral simultaneous stimulation. Given neglect represents an attentional, rather than primary, visual field disorder and may be associated with poor insight, self-reporting is unreliable. Where functionally significant deficits persist, referral for non-GP specialist assessment is required, and the DLA may consider return to driving on a conditional licence informed by specialist advice (neurologist/ophthalmologist) and practical driving assessment.

Role of the general practitioner in assessing visual standards in fitness to drive

1. Awareness

It is important that GPs are aware of national VA and VF standards for private and commercial licences from Austroads section 10.3 Medical standards for licensing in *Assessing fitness to drive* (national standards updated 22 June 2022).⁵

2. Screening

As the Australian population ages, the prevalence of cataracts, glaucoma and AMD

increases. Drivers may be unaware of visual changes, particularly if they develop gradually or affect peripheral vision, underscoring the importance of objective screening by a GP rather than relying solely on self-reported symptoms. Screening questions for general vision, peripheral field loss and driving function include:

- Do you ever have trouble seeing road signs, especially at night or in rain when it is darker?
- Do you feel your vision is not as sharp as before?
- Do you bump into objects or have falls?
- Do you struggle with glare from oncoming headlights?
- Do you avoid driving at night, in the rain or in unfamiliar areas?
- Have you had any near misses or car accidents?

Screening for visual deficits on examination includes VA testing using a Snellen/logMAR chart uncorrected, with pinhole to account for refractive error, +/- confrontational VF. Objective assessment is crucial as patients may not recognise gradual or peripheral deficits that could affect driving safety.

3. Knowing when to refer

GPs are not expected to perform detailed VA or VF testing; however, if there is doubt about a driver's visual capacity, they should be referred to a medical specialist for formal assessment.

This may include an optometrist to ascertain best corrected VA, and formal VF testing. Optometrists are a valuable part of the care team and can refract to optimise vision; assess binocular vision; assess contrast sensitivity, through the Melbourne Edge test; and refer to ophthalmologists or low-vision services such as Vision Australia. Optometrist review is appropriate for drivers who report increasingly blurred vision with age, glare when night driving, distorted vision, increased mechanical falls or car accidents. Drivers with borderline or inadequate VA and VF should be referred to an ophthalmologist for possible intervention and further specialist advice, which may be provided to the DLA for consideration of conditional licences.

Aside from eye-related conditions affecting vision, patients with neurological and systemic diseases may also benefit from optometry review for driving assessment.

Table 2. Visual standards for persons with vision in only one eye (monocular) or in persons with double vision (diplopic)⁵

Group	Licence type	Private standard	Commercial standard
Monocular	Unconditional	Not fit	Not fit
	Conditional	VA is at least 6/12 +/- corrective lenses in the only seeing eye At least 110° horizontal field within 10° above and below the horizontal midline in the only seeing eye 2-yearly review	VA is at least 6/9 +/- corrective lenses in their only seeing eye At least 140° horizontal field within 10° above and below the horizontal midline No other significant VF loss likely to impede visual driving performance 2-yearly review
Diplopia	Unconditional	Diplopia not within 20° from central fixation	Not fit
	Conditional	Diplopia within 20° from central fixation Diplopia managed satisfactorily with corrective lenses or an occluder worn while driving Must meet VA and VF criteria	Not fit

VA, visual acuity; VF, visual fields.

There are two separate forms for fitness to drive; this article focuses on the eyesight report, whereas a general fitness to drive assessment may also be required if the driver has other systemic conditions. GPs may prompt drivers with diabetes, hypertension, stroke, multiple sclerosis, sleep disorders or musculoskeletal diseases to seek review.¹¹ Given these conditions typically result in functional deficits that extend beyond visual impairment, drivers may require further assessment through occupational therapist driving assessors off road and on road as part of the general assessment for fitness to drive.

4. Knowing when to notify the driver licensing authority

Mandatory reporting to the DLA differs between states and territories, as outlined in Austroads section 3.3 of *Assessing fitness to drive*.¹² In Victoria (Vic), Western Australia (WA), Tasmania, New South Wales (NSW) and Queensland (Qld) there is no legal mandate for doctors to report drivers' fitness to drive (Table 3). This obligation lies with the driver, and the extensive range of driver conditions requiring notification is fully outlined in Part B. Medical standards in *Assessing fitness to drive*.¹¹ In the Australian Capital Territory (ACT), practitioners must report drivers who hold or apply for a heavy vehicle licence within 7 days if they

have a permanent or long-term condition likely to impair their ability to drive a heavy vehicle. They must also advise the driver of the report. In the Northern Territory (NT), practitioners who examine a licensed driver physically or mentally unfit to be licensed must notify the DLA. In South Australia (SA), practitioners have a duty to report the driver and notify them if they believe they would endanger the public (as a result of physical, mental illness, disability or deficiency) if they drove a motor vehicle.¹² A failure to notify the DLA when legally mandated in the ACT, NT and SA can expose the doctor to a breach of statutory duty, disciplinary action and potential civil liability if an accident occurs and it can be shown that failure to report contributed to ongoing unsafe driving.

At licence application or renewal, drivers must declare any diabetes, epilepsy and cardiovascular disease. Responsibilities of drivers are outlined in section 3.2 of *Assessing fitness to drive*.¹³ Routine age-based medical assessments for private licences begin at 75 years in ACT, NSW and Qld and at 80 years in WA. Victoria, Tasmania, NT and SA rely on condition-based or class-specific review (Table 3).¹⁴

Alternatively, practitioners have the right to report drivers to the DLA who refuse referrals, withhold information, lack insight into their eye condition or refuse to stop

driving when unsafe to do so. Otherwise, drivers who have permanent or long-term conditions that may impair their driving ability should be encouraged to notify the DLA themselves.

5. Early conversations

Initiating conversations with elderly drivers or those with progressive illnesses that may affect driving safety is vital in preparing for the future. It has been shown that individuals who engage in pre-planning and prepare for driving retirement have higher quality of life than those with no, or minimal, pre-planning.¹⁵ It can also help maintain the therapeutic relationship, as delaying conversations about driving and future expectations may detrimentally affect this relationship. Finally, GPs can consider alternative means of transport as a way of assisting a transition to driving retirement through considering eligibility for the taxi subsidy program for individuals with limited mobility, or transport assistance.

6. Documentation

Clear and thorough documentation of discussions, clinical findings, referrals and decisions is important. This documentation may also assist drivers in completing driver health questionnaire and clinical assessment records for the DLA.

Table 3. Legislation related to reporting and aged-based medical assessments^{14,16}

State/ territory	Routine age-based medical assessment (private licence)	Driver duty to self-report medical conditions affecting driving	Practitioner reporting duty	Good-faith legal protection	Key points for GPs
ACT	Annually from age 75 years	Must report long-term or permanent illness within 7 days	Mandatory for heavy-vehicle licence holders only	Yes	Annual reviews aged ≥75 years. Report if public risk; protected when acting in good faith.
NSW	Annually from age 75 years; on-road test from age 85 years, or modified licence ^A	Must report long-term illness	Discretionary	Yes	Yearly medicals aged ≥75 years. May report unsafe or non-compliant drivers.
Qld	Annually from age 75 years (medical certificate required)	Must report long-term incapacity	Discretionary	Yes	All drivers aged ≥75 years must hold a current medical certificate (F3712).
SA	None for class C; annual if aged ≥70 years and heavy-vehicle or motorcycle licence	Must report illness or injury affecting driving	Mandatory for all unfit drivers	Yes	Must notify DLA in writing; inform driver unless risk of harm.
WA	Annually from age 80 years	Must report new or worsening driving impairment	Discretionary	Yes	Annual assessment aged ≥80 years. Optional reporting; document clearly.
Vic	No fixed age; condition-based assessment only	Must report long-term condition or treatment affecting safety	Discretionary	Yes	No age-based trigger; assess when condition declared or suspected.
Tas	No fixed age; condition-based assessment only (self-assessment advised age ≥65 years)	Must report illness or eyesight decline	Discretionary	Yes	Encourage self-review aged ≥65 years; reporting optional, consent preferred.
NT	Assessment only when a condition is notified	Must report incapacity to registrar	Mandatory for all unfit drivers	No explicit protection	Must report in writing; no protection for voluntary reports.

^AFrom age 85 years, unrestricted licence requires on-road testing; alternatively, a modified licence with a local driving radius restriction may be chosen, typically 5–15 km from home, but can be more than 15 km in rural areas if needed to get to your nearest town.

ACT, Australian Capital Territory; DLA, driver licensing authority; GP, general practitioner; NSW, New South Wales; NT, Northern Territory; Qld, Queensland; SA, South Australia; Tas, Tasmania; Vic, Victoria; WA, Western Australia.

Case studies

CASE 1

A man aged 78 years in a rural town in Queensland presents with worsening vision bilaterally and says he avoids driving at night because of glare. He holds a current medical certificate and undergoes an annual medical assessment. His GP conducts a VA test noting VA 6/36 in the right eye correcting to 6/24 with pinhole, and 6/24 in the left eye correcting to 6/18 with pinhole. His GP recommends an optometrist review, who confirms moderate cataracts (right worse than left), appropriate for cataract surgery. He is referred to a visiting ophthalmologist, and the optometrist advises the driver to notify the Queensland Department of

Transport and Main Roads (TMR). Given the driver's vision is better than 6/24 with lenses in the better eye and rural location with limited access to public transport, he may be considered for a conditional licence to drive locally while awaiting ophthalmology review. Appropriate conditions would include daylight-only driving, avoidance of night and wet-weather driving because of glare and reduced contrast sensitivity, and restriction to a defined local area such as within 10–15 km of the driver's residence or distance closest to the nearest town as determined by TMR.

CASE 2

A female bus driver aged 63 years with a history of stroke presents to her GP

aiming for clearance to resume working. She denies visual disturbances, and her VA is 6/9 uncorrected bilaterally. Her GP screens her VF by confrontation and notices reduced fields superotemporally. The driver is referred to the optometrist for a formal VF test. A binocular Esterman is conducted, and this shows a quadrantanopia greater than three missed points with central loss. The optometrist explains to the driver that she is unable to drive with a private or commercial licence; however, the driver continues to disregard advice and drive a car. In this case, her GP may report to the DLA and has a legal obligation to do so in the NT and SA but not in any other states or territories.

Conclusion

Safe driving relies heavily on adequate VA and VF, and GPs play a vital part in identifying drivers whose vision may compromise road safety. By being familiar with national licensing standards, screening appropriately, and knowing when to refer or notify the DLA, GPs can help balance individual independence with community safety. Early conversations, clear documentation and multidisciplinary care with optometrists, ophthalmologists and occupational therapists ensure drivers can receive appropriate support through corrective interventions, conditional licensing or preparation for driving retirement. Ultimately, proactive and compassionate management of visual fitness to drive protects both drivers and the wider community.

Key points

- VA and VF mainly determine fitness to drive, with different standards for commercial and private licences.
- Conditional licences may be issued when drivers meet minimum visual standards with lenses, vehicle modification or restrictions.
- GPs can screen for visual impairment with questions, VA testing and confrontational fields, with referral to optometry or ophthalmology when in doubt.
- Legal obligations for reporting unfit drivers vary by state and territory; it is important that GPs are aware of local requirements.
- Early, well-documented conversations about driving retirement can help preserve the therapeutic relationship.

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Competing interests: None.

Funding: None.

Provenance and peer review: Commissioned, externally peer reviewed.

AI declaration: The authors confirm that there was no use of artificial intelligence (AI)-assisted technology for assisting in the writing or editing of the manuscript and no images were manipulated using AI.

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