



**IMPORTANT:** Please answer the questions in **BLOCK CAPITAL** letters using **BLACK INK**.  
Failure to provide full information for yourself, GP or consultant may result in your case being delayed.

**PART A: About you**

**Current driving licence details**

Title: \_\_\_\_\_ Full name: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
Address: \_\_\_\_\_  
Postcode: \_\_\_\_\_  
Email: \_\_\_\_\_ Contact number: \_\_\_\_\_

**Change of details**

If you have changed your contact information (address, name, email or contact number) since we last corresponded with you, please provide the NEW details in the box below.

**PART B: Healthcare professional for your condition**

**GP details**

GP name: \_\_\_\_\_  
Surgery name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Town: \_\_\_\_\_  
Postcode: \_\_\_\_\_  
Contact number: \_\_\_\_\_  
Email: \_\_\_\_\_  
Date last seen for this condition: \_\_\_\_\_

**Consultant details**

Consultant name: \_\_\_\_\_  
Speciality: \_\_\_\_\_ Department: \_\_\_\_\_  
Hospital name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Town: \_\_\_\_\_  
Postcode: \_\_\_\_\_  
Contact number: \_\_\_\_\_  
Email: \_\_\_\_\_  
Date last seen for this condition: \_\_\_\_\_

# Medical questionnaire – Parkinson's

If you are unsure of the answers, we advise you to discuss this form with your healthcare professional

## 1 Your condition

### 1.1 | How long have you been diagnosed with Parkinson's?

- |  |   |
|--|---|
| <input type="checkbox"/> Less than one year  | <input type="checkbox"/> 1 year to 3 years  |
| <input type="checkbox"/> 3 years to 13 years | <input type="checkbox"/> More than 13 years |

### 1.2 | Do you experience episodes of slowing up (off periods or freezing)?

You should not drive when you are likely to experience off periods or freezing

- |                              |   |
|------------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No → Go to 1.4 |
|------------------------------|---|

### 1.3 | If yes, are these periods sudden and unpredictable?

- |                              |                             |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------------------------|-----------------------------|

### 1.4 | Due to your Parkinson's do you experience sleepiness that affects safe driving?

- |                              |                             |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------------------------|-----------------------------|

### 1.5 | Have you had an on-road driving assessment in the last 3 years?

If yes, and you have a copy, please enclose it with this form

- |                              |                             |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------------------------|-----------------------------|

## 2 Your medication

### 2.1 | Do you need to take medication for your Parkinson's?

- |                              |                                       |
|------------------------------|---------------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No → Go to 3 |
|------------------------------|---------------------------------------|

### 2.2 | If yes, does your medication make you drowsy or confused when driving?

You should not drive when you experience drowsiness or confusion as a result of taking your medication

- |                              |                             |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------------------------|-----------------------------|

### 3 Healthcare professional

#### 3.1 | Have you been in contact (any phone, video or face to face consultation) with your healthcare professional about your Parkinson's in the last 12 months?

A healthcare professional could be your GP, consultant or specialist

☐ Yes

☐ No → Go to 4

#### 3.2 | If yes, who was the last healthcare professional you saw for your Parkinson's disease?

☐ GP

☐ Consultant / Nurse specialist at hospital clinic

### 4 Special controls

#### 4.1 | As a result of your medical condition, do you have to drive a vehicle with automatic gears?

☐ Yes

☐ No

#### 4.2 | As a result of your medical condition, do you need to drive a vehicle with special controls?

☐ Yes

☐ No

#### 4.3 | Select any modifications that you need to drive a car

☐ Modified transmission (10)

☐ Modified clutch (15)

☐ Modified braking system (20)

☐ Modified accelerator system (25)

☐ Pedal adaptations and pedal safeguards (31)

☐ Combined service brake and accelerator systems (32)

☐ Combined service brake, accelerator and steering systems (33)

☐ Modified control layouts (35)

☐ Modified steering (40)

☐ Modified rear view mirror (42)

☐ Modified driver seat (43)

#### 4.4 | Select any modifications that you need to drive a motorcycle, moped or tricycle

☐ Single operated brake (44.01)

☐ Adapted front wheel brake (44.02)

☐ Adapted rear wheel brake (44.03)

☐ Adjusted accelerator (44.04)

☐ Adjusted manual transmission & clutch (44.05)

☐ Adjusted rear view mirror (44.06)

☐ Adjusted commands (for example, light or indicators) (44.07)

☐ Seat height (allows the driver to have 2 feet on the surface at once and balance the wheel when stopping/standing) (44.08)

☐ Adapted footrest (44.11)

☐ Adapted hand grip (44.12)

☐ Motorcycle with sidecar only (45)

If you have ticked any of the above, you will need to return your driving licence with this completed form.



### **Applicant's authorisation**

You **must** fill in this section and must **not** alter it in any way. Please read the following information carefully and sign to confirm the statements below.

#### **Important information about fitness to drive**

- As part of the investigation into your fitness to drive, we (DVLA) may require you to have a medical examination and/or some form of practical assessment. If we do, the individuals involved in these will need your background medical details to carry out an appropriate assessment.
- These individuals may include doctors, orthoptists at eye clinics or paramedical staff at a driving assessment centre. We will only share information relevant to the medical assessment of your fitness to drive.
- Also, where the circumstances of your case appear to suggest the need for this, the relevant medical information may need to be considered by one or more of the members of the Secretary of State's Honorary Medical Advisory Panels. The membership of these Panels conforms strictly to the principle of confidentiality.

For information about how we process your data, your rights and who to contact, see our privacy notice at [www.gov.uk/dvla/privacy-policy](http://www.gov.uk/dvla/privacy-policy)

**This section must NOT be altered in any way.**

#### **Declaration**

I authorise my doctor, specialist or appropriate healthcare professional to disclose medical information or reports about my health condition to DVLA, on behalf of the Secretary of State for Transport, that is relevant to my fitness to drive.

I understand that the doctor that I authorise may pass this authorisation to another registered healthcare professional, who will be able to provide information about my medical condition that is relevant to my fitness to drive.

I understand that the Secretary of State may disclose such relevant medical information as is necessary to the investigation of my fitness to drive to doctors and other healthcare professionals such as orthoptists, paramedical staff and the Secretary of State for Transport's Honorary Medical Advisory panel members.

I declare that I have checked the details I have given on the enclosed questionnaire and that, to the best of my knowledge and belief, they are correct.

I understand that it is a criminal offence if I make a false declaration to obtain a driving licence and can lead to prosecution.

Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**I authorise the Secretary of State to correspond with medical professionals by email.** Yes ☐ No ☐

If you would like to be contacted about your application by email or text message (SMS), please tick the appropriate boxes. If not, DVLA will continue to contact you by post. Email ☐ SMS (text) ☐

If you would like to be contacted about your application by email or text message (SMS) by a healthcare professional acting on behalf of DVLA, please tick the appropriate boxes. If not, you'll be contacted by post.

Email ☐ SMS (text) ☐



Driver & Vehicle  
Licensing  
Agency

**Note:** there will be a delay with your case if you do not give us all the information we need, including the full name, address and telephone number of your healthcare professional.

Please use the contact details below to return your completed medical questionnaire to the **Drivers Medical Group**.

**By post:**

Drivers Medical Group  
DVLA  
Swansea  
SA99 1DF

**By email:**

[eftd@dvla.gov.uk](mailto:eftd@dvla.gov.uk)

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