



PART A: ABOUT YOU

Please complete this form in **BLOCK CAPITAL** letters using **BLACK INK**

Title _____ Full name _____

Full address _____

Postcode _____ Date of birth _____

NHS number _____ Driver number _____
(If known)

Mobile number _____ Home number _____
(Optional) (Optional)

Email _____
(Optional)

PART B: HEALTHCARE PROFESSIONAL DETAILS

Please provide the details of the GP OR consultant you have seen for this condition

IMPORTANT: You must provide the full name and address of your GP and/or consultant. The form will be returned to you resulting in delays.

GP DETAILS

Full name _____

Surgery _____

Full address _____

Postcode _____ Phone number _____

Email _____
(If known)

Date last seen by GP for this condition _____

CONSULTANT DETAILS

Title _____ Full name _____

Department _____

Full Hospital
address _____

Postcode _____ Phone number _____

Email _____
(If known)

Date last seen by consultant for this condition _____



If you are unsure of the answers, it would be advisable to discuss the form with your mental health doctor or nurse

1. Please give the name of your medical condition or conditions. _____

2. Are you currently taking any medication for this condition? Yes ☐ No ☐

3. Please give the name and dosage (the amount you take) of all the current medication prescribed to you for the above conditions:

<u>Name of Medication</u>

<u>Reason for taking</u>

4. In the past 12 months, have you required treatment for;

a) Alcohol dependence? Yes ☐ No ☐

b) Drug dependence? Yes ☐ No ☐

c) Have you had supervised detoxification? Yes ☐ No ☐

If Yes to either Q4a,b or c, please give most recent date of treatment/detoxification

DD	MM	YY
<input type="text"/>	<input type="text"/>	<input type="text"/>

5. In the past 6 months, have you persistently misused alcohol? Yes ☐ No ☐

6. In the past 6 months, have you persistently misused illicit drugs? Yes ☐ No ☐

If Yes, please give brief details: _____

7. In the past 12 months, have you required admission or referral to a hospital or clinic for psychiatric treatment? Yes ☐ No ☐

If Yes, please give the dates and details: _____

8. In the past 12 months, have you suffered any fits or blackouts? Yes ☐ No ☐

If Yes, please give date

Day	Month	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>

9. Please supply the dates below of any phone, video or face to face consultations for the condition declared at Q1.

Seen by Consultant

Day	Month	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>

Seen by CPN

<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------

Seen by GP

<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------



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

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 the 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 healthcare professionals via electronic channels (fax or email)

Yes

☐

No

☐

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

I authorise a representative of the Secretary of State to contact me via Email or SMS text in relation to this application (Please Tick):

Email

☐

Yes

☐

No

SMS (Text)

☐

Yes

☐

No



Driver & Vehicle
Licensing
Agency

Note: please complete and return all pages of this medical questionnaire and authorisation form. If you do not give us all the information we need including the full name, address, and telephone number of your GP/Consultant then there will be a delay with your case.

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 Fax:

0300 083 0083

Electronically – Email:

eftd@dvla.gov.uk

Please keep this page for future reference.

Find out about DVLA's online services

Go to: www.gov.uk/browse/driving

