Driver & Vehicle Licensing Agency

Confidential medical information

CN1 ONLINE
Rev Sept 14

PART A: ABOUT YOU

Please answer the questions on this form in **BLOCK CAPITAL** letters using **BLACK INK**

Title: (Mr, Mrs, Miss, Other?) Surname: Date of Birth:

First Name(s): Driver No: *(if known)*

Address:

Postcode

Telephone Number(s):
Home
Mobile

Email

PART B: ABOUT YOUR GP AND YOUR CONSULTANT

GP's Name and Address

Dr:

Postcode:

Consultants Name and Address

Title:

Department:

Postcode:

TEL No: *(Including dialling code)*

TEL No: *(Including dialling code)*

Date last seen by GP (For this condition)

Date last seen by Consultant (For this condition)

If you have more than one consultant, please give their name, department and address on a separate sheet.

GP email address *(if known)*

Consultants email address *(if known)*

NHS number *(if known)*

PART C: Please give details of other clinics you are attending below

Name of clinic & Department	Reason for attendance	Date last seen

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Questionnaire to assess your medical fitness to drive.

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

1. Please tick the appropriate box(es) if you have suffered from any of the following conditions:

		Yes	No		Day	Month	Year
a)	Multiple Sclerosis	☐	☐	Date of diagnosis			
b)	Have you had a relapse or relapses?	☐	☐	Date of relapse			
				Date of relapse			
				Date of relapse			
2. a)	Motor Neurone Disease	☐	☐	Date of diagnosis			
b)	Huntington's Disease	☐	☐	Date of diagnosis			
c)	Other condition	☐	☐	Please give details			

3. Please give the name and dosage (the amount you take) of all current medication taken by you

Name of Medication	Dosage	Reason for taking

3a Does the medication you take make you drowsy or confused when driving? Yes ☐ No ☐

4. Do you need help from another person with your day to day living? Yes ☐ No ☐

If Yes, please give details of how they help you: _____

5. Has your condition caused problems with your eyesight? (such as your visual field, double vision) Yes ☐ No ☐

If Yes, please give details of how your eyesight is affected? _____

NAME:	DOB:	REF:
DRIVER NUMBER:		

6. Please give the date of your last and next appointment with your doctor or consultant

	Doctor			Consultant		
	Day	Month	Year	Day	Month	Year
Date of last appointment						
Date of next appointment						

7. Have you already had an on road driving assessment? Yes ☐ No ☐
If Yes, please provide a copy of the driving assessment report

8. As a result of your medical condition, do you need to drive a vehicle with automatic gears? Yes ☐ No ☐

As a result of your medical condition, do you need to drive a vehicle with special controls? Yes ☐ No ☐

If Yes, please indicate what controls you need.

a) 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)*

b) 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 *(light, indicators etc.)* *(44.07)*
☐ Seat height *(allows the driver to have two feet on the surface at once and balance the wheel when stopping/standing)* *(44.08)*
☐ Adapted foot rest *(44.11)*

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Applicants declaration

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 release information relevant to the medical assessment of your fitness.
- 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.

All data held by DVLA is used for internal evaluation of the quality of our services.

This section must NOT be altered in any way.

Declaration

I authorise my Doctor(s) and Specialist(s) to release reports/medical information about my condition relevant to my fitness to drive, to the Secretary of State's medical adviser.

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, orthoptists, paramedical staff and 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 :

Inform my Doctor(s) of the outcome of my case **Yes** ☐ **No** ☐

Release my medical information, and any other relevant information, to my doctor(s) by postal or electronic (fax or email) channels **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**

NAME:	DOB:	REF:
DRIVER NUMBER:		

Driver & Vehicle Licensing Agency

Note: please fill in and return all pages (1-4) of this medical questionnaire and consent/declaration. 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 filled in medical questionnaire to the Drivers Medical Group.

By Post

Drivers Medical Group
DVLA
Swansea
SA99 1DF

By fax

0300 083 0083

Please keep this page (5) for future reference.