



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 – vocational

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

1. Do you need to take medication for your Parkinson’s disease? Yes No
- a) Do you currently experience side-effects from your medication which are likely to impair safe driving? Yes No

2. Date of diagnosis.

DD	MM	YY

3. Do you experience:
- a) Involuntary movements? Yes No
- b) Sudden and unpredictable severe slowing up (off periods or freezing)? Yes No
- c) Slowness of reaction times? Yes No
- 4a. Do you need another person to help with domestic tasks, for example, shopping, cooking and cleaning? Yes No
- 4b. Do you need another person to help you with your personal care? Yes No
- If yes, please give the details: _____
-

5. Because of your condition:
- a) Do you feel excessively sleepy when driving? Yes No
- b) Have you fallen asleep while driving in the last 12 months? Yes No
- c) Have you been involved in any road traffic accidents? Yes No
- If yes, please give details: _____
-

- d) Have you had any problems while driving? Yes No
- If yes, please give details: _____
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- 6a. Do you **need** to drive a Group 1 vehicle fitted with special controls or automatic transmission? (Cars and motorcycles) Yes No
- 6b. Do you **need** to drive a Group 2 vehicle fitted with special controls or automatic transmission? (Bus, lorry, medium sized vehicles over 3500kg and minibus) Yes No
- 6c. Have you told us before that you need special controls or automatic transmission? Yes No
- 6d. Since your last licence was issued have you had any additional controls fitted to your vehicle? Yes No

PK1V

7. Please supply the dates below of any phone, video or face to face consultations for this condition with your:

	DD	MM	YY
Consultant Print name _____			

Parkinson's nurse specialist at the hospital Print name _____			
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GP Print name _____			
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a) If known, please supply the date of your next appointment with your:

	DD	MM	YY
Consultant Print name _____			

Parkinson's nurse specialist at the hospital Print name _____			
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GP Print name _____			
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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 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

Please keep this page for future reference.



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We invest in people Gold

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