Confidential medical information

V1V
Rev Jul 22

PART A: ABOUT YOU

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

Title ____________ Full name ________________________________

Full address ________________________________

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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 and Consultant you have seen for this condition

IMPORTANT: Failure to provide your GP/Consultant's full information will result in your case being delayed.

GP DETAILS

Full name ________________________________

Surgery ________________________________

Full address ________________________________

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Postcode ________________ Phone number ________________

Email ________________________________
(If known)

Date last seen by GP for this condition ________________

CONSULTANT DETAILS

Title ____________ Full name ________________________________

Department ________________________________

Full hospital address ________________________________

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Postcode ________________ Phone number ________________

Email ________________________________
(If known)

Date last seen by consultant for this condition ________________

Driver & Vehicle Licensing Agency

V1V
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Medical questionnaire – vision – vocational

If you are unsure of how to answer these questions, you can discuss the form with your doctor or optician

Please answer **all** questions:

1. a. Can you read a number plate from 20 metres in good light with glasses or contact lenses if worn? Yes ☐ No ☐

   b. Has your doctor or optician advised you that your eyesight **does not currently** meet the minimum standard for driving? Visual acuity of 6/12 (0.5) or better may be achieved with the aid of glasses or contact lenses if necessary. Yes ☐ No ☐

   c. Has your doctor or optician advised you that your eyesight **does not currently** meet the minimum standard for vocational driving? Your visual acuity must be of at least 6/7.5 (0.8) in the better eye and at least 6/60 (0.1) in the other eye. This may be achieved with glasses or contact lenses if necessary. Yes ☐ No ☐

2. a. Do you need to wear glasses or contact lenses to meet the minimum eyesight standard when you drive cars or motorcycles? Yes ☐ No ☐

   b. Do you need to wear glasses or contact lenses to meet the legal eyesight standard to drive a bus or lorry? Yes ☐ No ☐

3. Do you have total loss of sight in one eye, monocular vision? Yes ☐ No ☐

   If yes, please give date of loss Month ☐ Year ☐

4. Do you have any of the eyesight conditions listed below affecting either eye? If yes, please tick appropriate box(es) below Yes ☐ No ☐

		Right	Left
a)	Retinitis Pigmentosa	☐	☐
b)	Glaucoma	☐	☐
c)	Laser treatment in either eye for diabetic eye disease or another eye condition?	☐	☐
	If yes, please give the date of your last laser treatment	Month ☐	Year ☐
d)	Macular degeneration	☐	☐
e)	Cataracts with an intolerance to glare (difficulty seeing in the presence of bright light)	☐	☐

You do not need to tell us if you have cataracts without intolerance to glare, or if you have had successful surgery to remove cataracts.

5. Do you have any other medical condition not specified at question 4 affecting either eye. Yes ☐ No ☐

   a) If yes, which eye is affected Right ☐ Left ☐

   b) If yes, please give details ______________________

6. Has your doctor or optician ever told you that you have a visual field defect? *(Do not include long or short sightedness)* Yes ☐ No ☐

7. Do you have double vision (diplopia)? Yes ☐ No ☐

   a) If yes, do you ensure any double vision is suppressed or controlled when driving? Yes ☐ No ☐

   b) Please tick in the box below how the double vision is controlled

   Patch or glasses with a frosted lens? ☐ Glasses with a prism? ☐ Other ☐

   If you have ticked “Other” please specify ______________________

8. Please give details of all medication taken by you including eye drops

Medication	Dosage	Reason for Taking

9. Please supply the dates below of any phone, video or face to face consultations for this condition?

	Doctor	Consultant
Date of last contact		
Date of next contact		

10. What was the date of your last eye examination? ☐☐☐

Driver & Vehicle
Licensing
Agency

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 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 (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

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