Driver & Vehicle Licensing Agency

Confidential medical information

DIZ1V

DIZ1V
Rev Jul 22

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 and Consultant you have seen for this condition
IMPORTANT: You must provide their full name and address, or the form will be returned to you, delaying your application.

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 _____

Driver & Vehicle Licensing Agency

Medical questionnaire – dizziness – vocational

DIZ1V
Rev Nov 15

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

1. In the past 12 months, have you experienced any episodes of severe dizziness? Yes ☐ No ☐ ***If no, please go to Q5***

   If yes, please give dates: First ☐☐☐ Last ☐☐☐ Other ☐☐☐

2. If known please give the cause

   a) Labyrinthitis Yes ☐ No ☐
   b) Meniere's Disease Yes ☐ No ☐
   c) Vertigo Yes ☐ No ☐
   d) Migraine Yes ☐ No ☐
   e) Other, please give details _____

   _____

3a. Are the attacks disabling or would they be likely to affect your driving if they were to occur when you are driving? Yes ☐ No ☐

3b. Do you always have warning of the attacks? Yes ☐ No ☐

3c. If yes to question 3b, would you have sufficient time to stop your vehicle safely? Yes ☐ No ☐

4. Have you or are you receiving treatment to control the attacks? Yes ☐ No ☐

   If yes, please give details of treatment for this condition _____

   _____

   _____

   _____

5. Have any of the episodes ever caused a blackout? Yes ☐ No ☐

   If yes, please provide date of blackout ☐☐☐

6. 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	☐☐☐	☐☐☐

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**

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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