



**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 \_\_\_\_\_



# Medical questionnaire – cognitive impairment

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

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

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

	Doctor			Consultant		
Date of last contact	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Date of next contact	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

3. 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.

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4. In the past 12 months have you regularly misused alcohol? Yes  No

5. In the past 12 months have you taken illicit drugs? Yes  No

6. Do you need to drive a vehicle fitted with special controls or automatic transmission? (If no, do not answer Q6a/b) Yes  No

a) Have you told us before that you need special controls or automatic transmission? (If yes, please answer Q6b) Yes  No

b) Since your last licence was issued have you had any additional controls fitted to your vehicle? Yes  No



**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](http://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



**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](mailto: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](http://www.gov.uk/browse/driving)

