Driver & Vehicle Licensing Agency

Confidential medical information

CN1V

CN1V
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 – chronic neurological – vocational

CN1V
Rev Feb 19

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

a) 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?

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

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

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

8. Do you need to drive a vehicle fitted with automatic transmission for Group 1 (cars and/or motorcycles) or Group 2 (buses and/or lorries)? Yes ☐ No ☐

Please indicate: ☐ **Group 1** ☐ **Group 2**

Do you need to drive a vehicle fitted with special controls for Group 1 (cars and/or motorcycles) or Group 2 (buses and/or lorries)? Yes ☐ No ☐

Please indicate: ☐ **Group 1** *(8a and b below)* ☐ **Group 2** *(8c on page 4)*

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)*

c) **Select any modifications that you need to drive Group 2 vehicles.**

- ☐ 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)*

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

CUSTOMER SERVICE EXCELLENCE CSE