Driver & Vehicle Licensing Agency

CG1

CG1
Rev May 24

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:

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Medical Questionnaire – Cognitive impairment

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

1. Have you, your family or healthcare professionals noticed a change in your memory?

Yes ☐ No ☐

2. Have you seen a healthcare professional, sought advice, or been diagnosed with problems in relation to your memory? Put X in the box that applies.

Dementia ☐

Alzheimer's disease ☐

Cognitive impairment ☐

Awaiting diagnosis ☐

a) Who was that with?

GP ☐ Consultant ☐ Nurse ☐ Other ☐

b) Please tell us the date you last saw the healthcare professional above:

DD	MM	YY

3. Do you need help from another person with your day to day living because of problems with your memory?

Yes ☐ No ☐ **Go to Q4**

a) If yes, what do you need help with? Put X in all boxes that apply.

Assistance when driving, for example control layout, supervision ☐

Directions in a familiar place ☐

Operating household appliances ☐

Paying bills ☐

Remembering to take medication ☐

4. Have you had a driving assessment?

Yes ☐ No ☐

a) If yes, please tell us the date you attended your driving assessment.

DD	MM	YY

b) Is a copy of the driving assessment report available?

Yes ☐ No ☐

If available, please provide a copy of the driving assessment report.

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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 (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

Electronically – Email:

eftd@dvla.gov.uk

Please keep this page for future reference