



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: _____



Medical questionnaire – mental health

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

1. Have you been diagnosed with a mental health condition?

Yes

No

If no, DO NOT complete the rest of the form

2. Please confirm what mental health condition you have been diagnosed with;
(Put **X** in all boxes that apply)

a) Anxiety/ depression

(Without any impairment of concentration, memory or agitation)

b) Anxiety/ depression

(With suicidal thoughts or impairment in concentration, memory or agitation)

c) Bipolar affective disorder

d) Eating disorder *(Anorexia nervosa, bulimia)*

e) Obsessive compulsive disorder / post-traumatic stress disorder

f) Personality disorder *(Any type)*

g) Schizophrenia/ psychosis/ delusional disorder/ schizoaffective disorder

h) Other *(Please specify):* _____

3. Have you had any contact (any phone, video or face to face consultation) with your
healthcare professional about your mental health condition in the last 12 months.

Doctor

DD	MM	YY
<input type="text"/>	<input type="text"/>	<input type="text"/>

Consultant

<input type="text"/>	<input type="text"/>	<input type="text"/>
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Community Psychiatric Nurse

<input type="text"/>	<input type="text"/>	<input type="text"/>
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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. If not, DVLA will continue to contact you by post. Email SMS (text)

If you would like to be contacted about your application by email or text message (SMS) by a healthcare professional acting on behalf of DVLA, please tick the appropriate boxes. If not, you'll be contacted by post.

Email SMS (text)



Driver & Vehicle
Licensing
Agency

Note: there will be a delay with your case if you do not give us all the information we need, including the full name, address and telephone number of your healthcare professional.

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

By email:

eftd@dvla.gov.uk

Please keep this page for future reference.



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We invest in people Gold

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