Driver & Vehicle Licensing Agency

V1
Rev May 24

V 1

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 – vision

V1
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1 Your vision condition(s)

1.1 What is your vision condition?

Tick all that apply

- ☐ Blepharospasm
- ☐ Diabetic Retinopathy (with laser treatment)
- ☐ Glaucoma
- ☐ Nyctalopia (Night Blindness)
- ☐ Retinitis Pigmentosa
- ☐ Double Vision (Diplopia) **complete section 3**
- ☐ Other vision condition(s): _____

1.2 How many functioning eyes do you have?

A 'functioning eye' means that you have sight in that eye.

- ☐ One
- ☐ Two

1.3 Which eye does your condition affect?

- ☐ Both eyes
- ☐ Left eye
- ☐ Right eye

1.4 Have you ever had laser treatment for an eye condition?

Do not include surgery for long/short sightedness or cataracts

- ☐ No ➔ **go to 2**
- ☐ Yes, in one eye
- ☐ Yes, in both eyes

1.5 If yes, have you told us about your most recent laser treatment?

- ☐ Yes
- ☐ No

2 Field of vision

2.1 | Has a consultant or eye specialist said you have a problem with your field of vision?

Do not include long or short sightedness

☐ Yes ☐ No ➔ **go to 3**

2.2 | If yes, is your visual field problem caused solely by an eye condition?

☐ Yes ➔ **Go to 3** ☐ No

2.3 | If no, is your visual problem caused by any of the following?

☐ Brain tumour ☐ Head injury

☐ Stroke ☐ Other (please specify) _____

_____

3 Double vision (Diplopia)

3.1 | Do you have double vision?

☐ Yes ☐ No ➔ **Go to 4**

3.2 | How is your double vision (diplopia) controlled?

☐ Patch / Prism / Frosted glasses / Lenses ☐ Other ☐ Not controlled

3.3 | Have you ever seen an eye specialist about your double vision (diplopia)?

☐ Yes ☐ No

3.4 | Have you had contact (by phone, video, or face to face consultation) with your eye specialist about your double vision (diplopia) in the last 12 months?

☐ Yes ☐ No

3.5 | You must confirm you've read and understood the following information on double vision

Information: double vision

It can take 3 months or more for you to adapt to driving wearing a patch, prism, frosted glasses or lenses because:

- your ability to judge distances may be affected
- you may not be so aware of objects each side of you

Do not drive until your doctor or optician advises you've fully adapted to wearing a patch, prism, frosted glasses, or lenses.

☐ I have double vision and confirm I've read and understood the above information (tick)

4 Standards of vision for driving

4.1 | Do you meet the minimum eyesight standard for driving?

Minimum eyesight standard for driving

1. You must be able to read (with glasses or contact lenses, if necessary) a car number plate, made after 1 September 2001, from 20 metres.
2. You must not have been told by a doctor or optician that your eyesight is currently worse than 6 /12 (decimal 0.5) on the Snellen scale

☐ Yes ☐ No

☐ Yes, with glasses or corrective lenses

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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.