Driver & Vehicle Licensing Agency

CN1V

**CN1V**
*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 – chronic neurological – vocational

**CN1V**
*Rev Feb 19*

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

1. Please tick the appropriate box(es) if you have suffered from any of the following conditions:

| | | Yes | No | | DD | MM | YY |
|---|---|---|---|---|---|---|---|
| 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 |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

3a 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 or 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 | | |
|---|---|---|---|---|---|---|
| | DD | MM | YY | DD | MM | YY |
| 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 cars or motorcycles (Group 1) or buses or lorries (Group 2)? 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 2 feet on the surface at once and balance the wheel when stopping/standing)* *(44.08)*
- ☐ Adapted footrest *(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)*

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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.