Driver & Vehicle Licensing Agency

PK1

PK1
Rev May 25

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 – Parkinson's

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

Your condition

1 Do you experience episodes of slowing up? (for example, off periods or freezing)

You should not drive when you are likely to experience off periods or freezing.

Yes ☐ No ☐ Go to Q2

a) If **'Yes'**, are these episodes sudden and unpredictable?

Yes ☐ No ☐

2 Do you experience slowness of reaction times or involuntary movements?

Yes ☐ No ☐

3 Due to your Parkinson's do you experience sleepiness that can affect your ability to control your vehicle safely?

Yes ☐ No ☐

4 Do you have problems with fatigue or weakness that are likely to make driving unsafe?

Yes ☐ No ☐

5 Have you had an on-road driving assessment in the last 12 months?

Yes ☐ No ☐

If **'Yes'**, and you have a copy, please enclose it with this form.

Treatment

6 Do you have a deep brain stimulator implanted for movement disorder?

Yes ☐ No ☐

Special controls

7 As a result of your health condition, do you have any problems with your limbs that affect your ability to control your vehicle safely?

Yes ☐ No ☐ Go to Q9

a) As a result of your health condition, do you have to drive a vehicle with special controls?

Yes ☐ No ☐

b) If **'Yes'**, please tell us of any modifications that you need to drive a car:

- transmission (10) ☐
- clutch (15) ☐
- braking system (20) ☐
- accelerator system (25) ☐
- pedal adaptions and safeguards (31) ☐
- combined service brake and accelerator systems (32) ☐
- combined service brake, accelerator and steering systems (33) ☐
- control layouts (35) ☐
- steering (40) ☐
- rear view mirror (42) ☐
- driver seat (43) ☐

If **'Yes'**, please tell us of 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 and 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 footrest (44.11) ☐
- adapted hand grip (44.12) ☐
- motorcycle with sidecar only (45) ☐

8 As a result of your health condition, have you been told that you can only drive a vehicle with automatic gears? Do not mark 'yes' if you drive a vehicle with automatic gears by choice.

Yes ☐ No ☐

Healthcare professional

9 Who was the last healthcare professional you saw for your Parkinson's (any phone, video, or face to face consultation)?

GP ☐ Consultant ☐ Nurse specialist at hospital clinic ☐

a) Please tell us the date of your last contact with that healthcare professional:

DD	MM	YY

b) Which healthcare professional are you due to see at your next appointment for your Parkinson's (any phone, video, or face to face consultation)?

GP ☐ Consultant ☐ Nurse specialist at hospital clinic ☐

c) Please tell us the date of your next appointment:

DD	MM	YY

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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.