



Medical Fitness to Drive

Please answer all questions and make sure you sign and date the enclosed consent and declaration.
If possible, use **BLACK INK** only.

1 Your details:

Full name: _____ Date of birth: _____
 Address: _____
 Postcode: _____ Phone number: _____
 Driver number: _____ *Please tick box if you wish correspondence either by Fax or E-mail*
If you agree we will do so wherever possible. To cancel your agreement you must confirm in writing

E-mail address: _____ Fax: _____

2 Your doctor's details:

Name of your doctor (or medical practice): _____
 Address: _____
 Postcode: _____ Phone number: _____
 E-mail address: _____ Fax: _____
 Date you last saw your doctor for this condition: _____

3 Clinic and hospital specialists

Please tick which clinic or hospital specialists you have seen and the most recent date you've seen them within the past 12 months.

	GP	Consultant	Date(s):
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye clinic	<input type="checkbox"/>	<input type="checkbox"/>	_____
Alcohol Problem Clinic	<input type="checkbox"/>	<input type="checkbox"/>	_____
Drug Problem Clinic	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurology or neurosurgery	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiology	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatry	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sleep clinic	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other (please say which below)	<input type="checkbox"/>	<input type="checkbox"/>	_____

If you have ticked any of the above, please give the name of the consultant or doctor and the hospital's address below. If you see a community psychiatric nurse, counsellor, diabetic nurse, eye specialist or opticians, please give their name and the address of the hospital or clinic below.

Reason for going to the clinic or specialists: _____
 Name of doctor/consultant/other (see above): _____
 Address of the hospital: _____
 Hospital record number (if known): _____ Hospital phone number: _____

Reason for going to the clinic or specialists: _____
 Name of Doctor/Consultant/Other(see above): _____
 Address of the hospital: _____
 Hospital record number (if known): _____ Hospital phone number: _____

(Please continue on another sheet if necessary)

NAME	DOB	REF
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If you knowingly give false information you are liable to prosecution. Please answer all the questions. If you wish to add anything extra, please write on a separate sheet. If you have any difficulty answering the questions, you might seek help from your General Practitioner.

About your Medical Condition

1 What is the medical condition from which you suffer?

2 Please give the approximate dates of diagnosis.

3 Was your condition caused by an illness?

Please tick appropriate box

NO YES

If YES, please state nature of illness

4 Was your condition caused by an accident?

NO YES

If YES, please give details

5 How does your condition affect you

(a) when driving?

(b) generally, i.e. in your daily living?

6 Is the condition improving?

YES NO

7 Please give details of the medication/treatment you are receiving now

8 As a result of your medical condition, do you (or will you)

NO YES

drive a vehicle fitted with special controls or automatic transmission which enables you to overcome the effect of the condition?

(Advice on special controls can be obtained from MAVIS TRL, Crowthorne, RG45 6XD Tel 01344 661000)

NAME	DOB	REF
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Consent and Declaration

Please read the following information carefully and then sign the statement below. This section **MUST** be completed and must **NOT** be altered in any way.

Important information about Consent

You will see that we have asked you for your consent for the release of medical reports from your doctors as we may require further information. In addition, as a part of the investigation into your fitness to drive, DVLA may require you to undergo a medical examination or some form of practical assessment.

In these circumstances, those personnel involved will require your background medical details to undertake an appropriate and adequate assessment. Such personnel might include Doctors, Orthoptists at eye clinics or Paramedical Staff at a Driving Assessment centre. Only information relevant to the assessment of your fitness to drive will be released.

In addition, where the circumstances of your case appear exceptional, the relevant medical information would need to be considered by one or more of the Secretary of State’s Honorary Medical Advisory Panels. The membership of these Panels conforms strictly to the principle of confidentiality.

All data held by DVLA is used for internal evaluation of the quality of our services.

Consent and Declaration

I authorise my Doctor(s) and Specialist(s) to release reports/medical information about my condition, relevant to my fitness to drive, to the Secretary of State’s medical adviser.

I authorise the Secretary of State to disclose such relevant medical information as may be necessary to the investigation of my fitness to drive, to Doctors, Paramedical staff and Panel members, and to inform my Doctor(s) of the outcome of the case where appropriate.

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: _____

DVLA USE ONLY

NAME:	DOB:	REF:
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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 1TU

By fax

0845 850 0095

By email

If you choose to e-mail the questionnaire you should note that this is not a secure means of communication and that DVLA accepts no responsibility for handling your e-mail until after it is received.

Email address

eftd@dvla.gsi.gov.uk

Please do NOT return this form with your medical questionnaire.