



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: \_\_\_\_\_ Contact Phone number: \_\_\_\_\_
Driver number: \_\_\_\_\_

\*\*Please tick box if you wish correspondence to be sent to you by fax or e-mail. Your preferred choice will be used wherever possible. Alternatively, conventional post will be used. You must confirm in writing if you wish to cancel the agreement.

[ ] E-mail address: \_\_\_\_\_ [ ] Fax: \_\_\_\_\_

2 Your doctor's details:

Name of your doctor: \_\_\_\_\_
Surgery 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.

Table with 4 columns: GP, Date(s), Consultant, Date(s). Rows include Diabetes, Eye clinic, Alcohol Problem Clinic, Drug Problem Clinic, Neurology or neurosurgery, Cardiology, Psychiatry, Sleep clinic, Other (please say which below).

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)

Table with 3 columns: NAME, DOB, REF



# Questionnaire to assess your medical fitness to drive

**If you are unsure of the answers, we advise you to discuss the form with your Doctor.**

1. Please confirm which condition you have been diagnosed with.  
[tick the appropriate boxes]

a) Narcolepsy  b) Sleep Apnoea Syndrome

c) Other  Please give details: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Date of your diagnosis: 

DAY	MONTH	YEAR
<input type="text"/>	<input type="text"/>	<input type="text"/>

3. Is your sleep condition now under control? YES  NO

a) If YES, how long has your sleep condition been under control? 

DAY	MONTH	YEAR
<input type="text"/>	<input type="text"/>	<input type="text"/>

4. Are you now free of excessive drowsiness? YES  NO

5. Please give details of your current treatment and date started: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Has your condition ever caused a driving accident? YES  NO

If **YES**, please give the approximate date and details of the accident. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. a) What is your neck size? \_\_\_\_\_  
b) What is your height? \_\_\_\_\_  
c) What is your weight? \_\_\_\_\_

8. Please give the date you were last seen for this condition by:  
  
Your Doctor \_\_\_\_\_ Your Consultant \_\_\_\_\_

NAME	DOB	REF
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# CONSENT

Rev Jul 07

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: \_\_\_\_\_

#### Electronic Release of Information

DVLA is able to communicate by fax and by e-mail. We can use it to request medical information from your doctor(s). We can also use it to receive relevant medical information sent by your Doctors, Orthoptists or relevant personnel associated with any medical enquiry, medical examination or practical assessment that may be required.

All information held by DVLA is treated with strict confidentiality. E-mails with personal information will be sent by DVLA to medical professionals only where a secure network is available. The security of the electronic transmission of information over the Internet cannot be guaranteed and DVLA cannot accept responsibility for e-mails or faxes sent by others, until they have been received by us. If you do not wish DVLA to communicate in this way or if we are unable to do so, conventional postage methods will be used instead. Should you wish to withdraw your agreement to communicate electronically by fax or e-mail at a later date such a request should be made by you in writing.

Do you agree to DVLA communicating with your Doctors, Orthoptists or relevant personnel by fax and e-mail? YES  NO

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 1DF

**By fax**

0845 850 0095

**By Email**

DVLA will always treat the information you send with the strictest confidence. However, as the security of the internet cannot be guaranteed, DVLA will be unable to send e-mails which contain personal information and advise that you also follow this policy.

If you feel at all concerned about emailing, please use another form of contact, e.g. post.

**Email address**

[eftd@dvla.gsi.gov.uk](mailto:eftd@dvla.gsi.gov.uk)