Driver & Vehicle Licensing Agency

Confidential medical information

M1V ONLINE
Rev Sept 14

PART A: ABOUT YOU

Please answer the questions on this form in **BLOCK CAPITAL** letters using **BLACK INK**

Title: (Mr, Mrs, Miss, Other?) Surname: Date of Birth:

First Name(s): Driver No: *(if known)*

Address: Postcode

Telephone Number(s):
Home
Mobile

Email

PART B: ABOUT YOUR GP AND YOUR CONSULTANT

GP's Name and Address

Dr:

Postcode:

TEL No: *(Including dialling code)*

Consultants Name and Address

Title:

Department:

Postcode:

TEL No: *(Including dialling code)*

Date last seen by GP (For this condition)

Date last seen by Consultant (For this condition)

If you have more than one consultant, please give their name, department and address on a separate sheet.

GP email address *(if known)*

Consultants email address *(if known)*

Hospital number *(if known)*

PART C: Please give details of other clinics you are attending below

Name of clinic & Department	Reason for attendance	Date last seen

Driver & Vehicle Licensing Agency

Questionnaire to assess your medical fitness to drive

M1V ONLINE
Rev Jul 17

If you are unsure of the answers, it would be advisable to discuss the form with your Mental Health Doctor or Nurse

1. Please give the name of your medical condition or conditions. _____

_____

2. Are you currently taking any medication for this condition? Yes ☐ No ☐

3. Please give the name and dosage(the amount you take) of all the current medication prescribed to you for the above conditions:

Name of Medication and Dosage	Reason for taking

4. In the past 3 years, have you required treatment for:

Alcohol dependence? Yes ☐ No ☐

Drug dependence? Yes ☐ No ☐

Has this included treatment of supervised detoxification? Yes ☐ No ☐

If Yes, please give the most recent date of treatment:

DD	MM	YY

5. In the past 12 months have you regularly misused alcohol? Yes ☐ No ☐

6. In the past 12 months have you misused illicit drugs? Yes ☐ No ☐

If **YES**, please give brief details: _____

_____

_____

7. Have you been advised by a healthcare professional that you have memory loss problems, episodes of confusion or difficulty with concentrating that affects safe driving? Yes ☐ No ☐

8. In the last 12 months, have you required admission or referral to a hospital or a clinic for psychiatric treatment? Yes ☐ No ☐

   If **YES**, please give the dates and details: _____

9. In the past 12 months, have you suffered any fits or blackouts Yes ☐ No ☐

   If YES, please give the dates: DD MM YY

10. Please supply the date you were last seen for the condition declared at Question 1.

	DD	MM	YY
Seen by Consultant:			
Seen by CPN:			
Seen by GP:			

Driver & Vehicle Licensing Agency

CONSENT

Consent to the release of medical information

IMPORTANT: Please read the following information carefully and sign and date the statement below and return this consent form with your questionnaire. We cannot proceed with enquiries into your fitness to drive until we receive both your completed questionnaire and consent form

- We have asked you for your consent for the release of medical reports from your doctors as we may require further information.
- As 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, Paramedical Staff or officers of the Secretary of State. Only information relevant to the assessment of your fitness to drive will be released.
- 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.

This section must NOT be altered in any way.

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 personal and medical information as may be necessary to the investigation of my fitness to drive, to Doctors, Orthoptists, Paramedical staff or Officers of the Secretary of State.

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 :

Inform my Doctor(s) of the outcome of my case **Yes** ☐ **No** ☐

Release my medical information, and any other relevant information, to my doctor(s) by postal or electronic channels **Yes** ☐ **No** ☐

If you would like to be contacted about your application by email or Text message (SMS), please tick the appropriate boxes (below). If not, DVLA will continue to contact you by post.

I authorise a representative of the Secretary of State to contact me via Email or SMS Text in relation to this application (Please Tick): Email ☐ **Yes** ☐ **No** **SMS (Text)** ☐ **Yes** ☐ **No**

If you tick either of these options, DVLA will contact you using an external service provider regarding this application only. Your email / mobile details will not passed on to any other Third Parties, or used for marketing purposes.

NAME:	DOB:	REF:
DRIVER NUMBER:		

Driver & Vehicle Licensing Agency

Note: please fill in and return all pages (1-4) of this medical questionnaire and consent/declaration. If you do not give us all the information we need including the full name, address and telephone number of your GP/Consultant then there will be a delay with your case.

Please use the contact details below to return your filled in medical questionnaire to the Drivers Medical Group.

By Post

Drivers Medical Group
DVLA
Swansea
SA99 1DF

By fax

0300 083 0083

Please keep this page (5) for future reference.