Driver & Vehicle Licensing Agency

# Confidential medical information

**V1 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)*

**Date last seen by GP**
(For this condition)

**Consultants Name and Address**

Title:

Department:

Postcode:

**TEL No:** *(Including dialling code)*

**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 |
|---|---|---|
| | | |
| | | |
| | | |

| NAME: | DOB: | REF: |
|---|---|---|
| DRIVER NUMBER: | | |

Driver & Vehicle Licensing Agency

# Eyesight

**V1 ONLINE**
*(Rev Feb 17)*

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

Please answer all questions:

1a. Can you read a number plate from 20 metres in good light with glasses or contact lenses if worn? Yes ☐ No ☐

1b. Has your doctor or optician advised you that your eyesight **does not currently** meet the minimum standard for driving? A visual acuity of 6/12 (0.5)or better must be achieved with the aid of glasses or contact lenses if necessary. Yes ☐ No ☐

2. Do you need to wear glasses or contact lenses when you are driving? Yes ☐ No ☐

3. Do you have any of the following from questions 3a – g, affecting either eye? Yes ☐ No ☐

If **Yes**, please tick appropriate box(es) below

| | | Right | Left |
|---|---|---|---|
| a) | Glaucoma | ☐ | ☐ |
| b) | Ocular hypertension | ☐ | ☐ |
| c) | Cataracts or any corneal dystrophies e.g. Fuchs?<br>(*Do not tick if you have had successful surgery to remove cataracts)* | ☐ | ☐ |
| d) | Macular degeneration or any other macular disease | ☐ | ☐ |
| e) | Retinitis Pigmentosa | ☐ | ☐ |
| f) | Any other eye condition not listed above?<br>Please give details of eye condition *(Do not include long or short sightedness)* | ☐ | ☐ |

_____

_____

_____

| | | | |
|---|---|---|---|
| g) | Laser treatment or injections into both eyes (or remaining eye if one eye only) for diabetic eye disease or another eye condition?<br>***(Do not include laser treatment for cataracts or corrective laser treatment for long/short sightedness)*** | ☐ | ☐ |

If **Yes**, please give the date of your last laser treatment / injections and reason for the treatment: Month ☐ Year ☐

_____

_____

_____

| NAME: | DOB: | REF: |
|---|---|---|
| DRIVER NUMBER: | | |

4. Has your doctor or optician ever told you that you have a visual field defect? *(Do not include long or short sightedness)* Yes ☐ No ☐

5. Do you have total loss of sight in one eye? Yes ☐ No ☐

   If **Yes,** please answer the following. ☐ ☐

   a) Which eye is affected? Left ☐ Right ☐

   b) Please give the date of the loss.

| Month | Year |
|---|---|
| | |

6. Do you have double vision (diplopia)? Yes ☐ No ☐

   a) If **Yes**, do you ensure any double vision is suppressed or controlled when driving? Yes ☐ No ☐

   b) Please tick in the box below how the double vision is controlled

   Patch ☐ Glasses ☐ Frosted Lens ☐ Prism ☐ Other ☐

   If you have ticked "Other" please specify _____

7. If you drive using one eye only, has your doctor confirmed that you have adapted to this? Yes ☐ No ☐

8. Have you had cataracts removed? Yes ☐ No ☐

9. Please give details of **all** medication taken by you including eye drops. If drops are used, please indicate for which eye.

| Medication | Reason for Taking | Right | Left |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

| NAME: | DOB: | REF: |
|---|---|---|
| DRIVER NUMBER: | | |

## 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 medical information, discovered during the investigation into my fitness to drive, to my Doctor(s)** **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.

**Find out about DVLA's online services**

**Go to:** www.gov.uk/browse/driving