Driver & Vehicle Licensing Agency

Confidential medical information

C1V ONLINE
(Rev Apr 12)

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:

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:

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 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	Reason for attendance	Date last seen

1. Please tell us what form of cancer you have (tick relevant box) and give the date of diagnosis. Please make sure **all** questions are answered.

	YES	NO	Date of Diagnosis
a) Brain Tumour	☐	☐	☐☐☐☐☐☐

If YES, please give details: _____

_____

	YES	NO	Date of Diagnosis
b) Pituitary Tumour	☐	☐	☐☐☐☐☐☐
c) Ocular Tumour	☐	☐	☐☐☐☐☐☐
d) Other	☐	☐	☐☐☐☐☐☐

If YES, please give details: _____

_____

2. As a result of your condition, have you ever suffered from any of the following?

	YES	NO	Date of Episode
a) Sudden disabling giddiness?	☐	☐	☐☐☐☐☐☐

If YES, please give details: _____

_____

	YES	NO	Date of Episode
b) Sudden disabling fainting?	☐	☐	☐☐☐☐☐☐

If YES, please give details: _____

_____

	YES	NO	Date of Episode
c) Blackout of loss of consciousness?	☐	☐	☐☐☐☐☐☐

If YES, please give details: _____

_____

	YES	NO
d) Any form of seizure?	☐	☐

If YES, please give:

	Awake	Asleep
Date of first seizure	☐☐☐☐☐☐	☐☐☐☐☐☐
Date of last seizure	☐☐☐☐☐☐	☐☐☐☐☐☐

NAME:	DOB:	REF:
DRIVER NUMBER:		

3. Please tell us what type of treatment you have had and the date it was given.

	YES	NO	Date of Treatment
a) Chemotherapy			
b) Radiotherapy			
c) Surgery			
d) Other			

If YES to any of the above please give details _____

4. Please give the date of your last and next appointment with your Doctor or Consultant.

	Doctor DD	Doctor MM	Doctor YY	Consultant DD	Consultant MM	Consultant YY
Date of last appointment						
Date of next appointment						

5. Please give the name and dosage of all the current medication prescribed to you.

Name of Medication	Dosage	Reason for taking

6. Does the medication make you drowsy or confused throughout the day? YES ☐ NO ☐

7. Do you have problems with fatigue? YES ☐ NO ☐

If YES, please give details: _____

		YES	NO
8.	a) Do you need to drive a Group 1 vehicle (car/motorcycle) fitted with special controls or automatic transmission?		
	b) Do you need to drive a Group 2 vehicle (lorry, bus medium sized vehicles over 3500kG and minibuses) fitted with special controls or automatic transmission?		
	c) Have you told us before that you need special controls or automatic transmission?		
	d) Since your last licence was issued have you had any additional controls fitted to your vehicle?		
9.	Do you have any other medical condition?		

If YES, please provide the names, addresses and telephone numbers of all doctors/specialists involved in your treatment.

Driver & Vehicle Licensing Agency

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 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** ☐

NAME:	DOB:	REF:
DRIVER NUMBER:		

Driver & Vehicle Licensing Agency

Note: please fill in and return all pages (1-5) 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

0845 850 0095

Please keep this page (6) for future reference.