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	☐	☐	
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)

DIAB1 ONLINE
(Rev. June 2005)

1. Is your diabetes treated by

a) Insulin NO ☐ YES ☐ b) Tablets NO ☐ YES ☐ c) Diet only NO ☐ YES ☐

If 1a is NO, please go straight to question 8

FOR INSULIN TREATED DIABETICS

2. Please give the date insulin treatment started **DD MM YY** ☐☐ ☐☐ ☐☐

3. Do you regularly undertake blood glucose monitoring? YES ☐ NO ☐

4. Since becoming insulin treated, have you ever experienced episode(s) of hypoglycaemia (low blood sugar)? NO ☐ YES ☐

If YES to Q4, please answer ALL of the following questions; if NO go straight to Q8

5. Do you **always** have warning symptoms when your blood glucose starts to fall (except if this occurs during sleep)? YES ☐ NO ☐

6. Have you had any episodes of **disabling** hypoglycaemia requiring help from another person during the last 12 months? (except if this occurs during sleep) NO ☐ YES ☐

If YES, please give the dates/details: _____

_____

_____

_____

7. Have you had an episode of hypoglycaemia whilst driving in the last 12 months? NO ☐ YES ☐

If YES, please give the dates/details: _____

_____

ABOUT OTHER MEDICAL CONDITIONS: this section must be answered by all applicants/licence holders

8. Do you need adaptations to help you safely control your vehicle? (e.g.) because of limb weakness or difficulty with touch/sensation) NO ☐ YES ☐

NAME	DOB	REF

DIAB1 ONLINE

(Rev. June 2005)

EYESIGHT – This section must be answered by all applicants/licence holders

9. Can you read, a standard size number-plate (with glasses or corrective lenses if necessary) from 20.5 metres (67 feet) or 20 metres (65 feet) where narrower characters (50mm wide) are displayed? YES ☐ NO ☐

10. Do you have total loss of sight in one eye? NO ☐ YES ☐

11. Have you had laser treatment for retinopathy to both eyes, or remaining eye if one eye only? NO ☐ YES ☐

12. Do you **currently** have cataracts in both eyes? NO ☐ YES ☐

IF YES: If you had your eyes tested within the last six months, please ask your Optician to enter details & the date of your last recorded visual acuity below.

ONLY TAKE THIS TO YOUR OPTICIAN **IF YOU HAVE CATARACTS IN BOTH EYES**

TO THE OPTICIAN:

Please only enter the patients visual acuities below, taken from the records, tested using the Snellen eye chart, if the patient **CURRENTLY** has cataracts in **BOTH EYES and you have tested your patient in the last 6 months**. Examination of your patient is not required.

UNCORRECTED				CORRECTED (Using prescription currently worn for driving)			
Right Eye		Left Eye		Right Eye		Left Eye	

Date visual acuity measured: ☐☐ ☐☐ ☐☐

Optician's Stamp Signature _____

ON RECEIPT, A FEE OF £11 WILL BE PAID BY DVLA
If you are VAT registered we will pay the fee, plus VAT at the standard rate on receipt of an invoice, which should be sent with the completed report

NAME	DOB	REF

CONSENT

(Rev Sept 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

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