Driver & Vehicle Licensing Agency

**Confidential medical information**

**CN1 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** | **Consultants Name and Address** |
|---|---|
| Dr: | Title: |
| | Department: |
| | |
| | |
| | |
| Postcode: | Postcode: |

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

**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)*

NHS 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

**CN1 ONLINE**
*Rev Jul 17 (EPOD V2)*

**Questionnaire to assess your medical fitness to drive.**

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

1. Please tick the appropriate box(es) if you have suffered from any of the following conditions:

| | | Yes | No | | Day | Month | Year |
|---|---|---|---|---|---|---|---|
| a) | Multiple Sclerosis | | | Date of diagnosis | | | |
| b) | Have you had a relapse or relapses? | | | Date of relapse | | | |
| | | | | Date of relapse | | | |
| | | | | Date of relapse | | | |

| | | Yes | No | | Day | Month | Year |
|---|---|---|---|---|---|---|---|
| 2. a) | Motor Neurone Disease | | | Date of diagnosis | | | |
| b) | Huntington's Disease | | | Date of diagnosis | | | |
| c) | Other condition | | | Please give details | | | |

3. Please give the date of last and next appointments with your doctor or consultant:

| | Doctor | | | Consultant | | |
|---|---|---|---|---|---|---|
| Date of last appointment | | | | | | |
| Date of next appointment | | | | | | |

4. Please give the name and dosage (the amount you take) of all current medication taken by you

| Name of Medication | Dosage | Reason for taking |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

4a Does the medication you take make you drowsy or confused when driving? Yes ☐ No ☐

5. 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 ☐

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

6. Do you need help from another person with your day to day living? Yes ☐ No ☐

   If Yes, please give details of how they help you: ____________________

   ____________________

   ____________________

7. Has your condition caused problems with your eyesight? Yes ☐ No ☐
   (such as your visual field, double vision)

   If Yes, please give details of how your eyesight is affected? ____________________

   ____________________

   ____________________

8. Have you already had an on road driving assessment? Yes ☐ No ☐
   If Yes, please provide a copy of the driving assessment report

9. Do you need to drive a vehicle fitted with special controls or automatic transmission? *If you answered No to question 9 you Do not need to answer questions 9a and 9b.* Yes ☐ No ☐

   a) Have you told us before that you need special controls or automatic transmission? *If you answered Yes to question 9a please answer 9b.* Yes ☐ No ☐

   b) Since your last licence was issued have you had any additional controls fitted to your vehicle? Yes ☐ No ☐

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## 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: | | |

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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