

**PART A: ABOUT YOU**Please answer the questions on this form in **BLOCK CAPITAL** letters using **BLACK INK**Title:  Surname:  Date of Birth:   
(Mr, Mrs, Miss, Other?)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:                  | <input type="text"/>  |
| <input type="text"/> | <input type="text"/>  |
| <input type="text"/> | <input type="text"/>  |
| <input type="text"/> | <input type="text"/>  |
| <input type="text"/> | <input type="text"/>  |
| Postcode:            | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |

**Consultants Name and Address**

|                      |   |
|----------------------|---|
| Title:               | <input type="text"/>  |
| <input type="text"/> | <input type="text"/>  |
| <input type="text"/> | <input type="text"/>  |
| <input type="text"/> | <input type="text"/>  |
| <input type="text"/> | <input type="text"/>  |
| Postcode:            | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |

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 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       |
|----------------------|-----------------------|----------------------|
| <input type="text"/> | <input type="text"/>  | <input type="text"/> |
| <input type="text"/> | <input type="text"/>  | <input type="text"/> |
| <input type="text"/> | <input type="text"/>  | <input type="text"/> |

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| NAME | DOB | REF |
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## 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.**

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

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2. Please give the name and dosage (the amount you take) of all the current medication taken by you **or** enclose a copy of your repeat prescription counterfoil. **(Continue overleaf if necessary.)**

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

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

|                                 | <u>Doctor</u>        |                      |                      | <u>Consultant</u>    |                      |                      |
|---------------------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|
|                                 | DD                   | MM                   | YY                   | DD                   | MM                   | YY                   |
| Date of <b>last</b> appointment | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Date of <b>next</b> appointment | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |

4. Does the medication make you drowsy or confused? YES ☐ NO ☐
5. Do you suffer from significant memory problems? YES ☐ NO ☐
6. Do you suffer from episodes of confusion? YES ☐ NO ☐
7. 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.

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8. In the past 12 months have you regularly misused alcohol? YES ☐ NO ☐
9. In the past 12 months have you taken illicit drugs? YES ☐ NO ☐
10. Do you need to drive a vehicle fitted with special controls or automatic transmission? YES ☐ NO ☐

If YES and you hold a full licence, please fill in the form D497 enclosed.  
*(Please note that you must be able to control your vehicle at ALL times)*

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Confidential medical information

Rev July 2012

**D497 form for Special Controls**

If you have said **YES**, that you need to drive a vehicle fitted with special controls or automatic transmission, you must now fill in the parts of the D497 that are relevant to you. The E.C. code will be updated onto your record and appear on your licence. Please write to us if your circumstances change. We can change or remove codes.

You will also need to return both parts of your current driving licence if you have not already done so.  
**You should only complete this form if you hold a full driving licence. If you hold provisional entitlement or are applying for a provisional licence if you need special controls the specific codes will be updated when you pass your driving test.**

**D497 – Vehicle Controls***For CARS and, if appropriate, BUSES and LORRIES*

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Automatic Transmission <b>78</b><br>(do not tick if driven by choice) | <input type="checkbox"/> Modified Transmission <b>10</b>                                       | <input type="checkbox"/> Modified Clutch <b>15</b>  |
| <input type="checkbox"/> Modified Braking System <b>20</b>                                     | <input type="checkbox"/> Modified Control Layouts <b>35</b><br>(e.g. lights, switches, wipers) | <input type="checkbox"/> Modified Steering <b>40</b><br>(only tick if to overcome a disability) |
| <input type="checkbox"/> Modified Rear View Mirror <b>42</b>                                   | <input type="checkbox"/> Modified Driver Seat <b>43</b>  | <input type="checkbox"/> Modified Accelerator System <b>25</b>                                  |
| <input type="checkbox"/> Combined Braking & Accelerator System <b>30</b>                       |  |   |

**D497 – Motorcycle Controls**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Single Operated Break <b>44.1</b>                      | <input type="checkbox"/> Adjusted hand operated brake (front wheel) <b>44.2</b>  | <input type="checkbox"/> Adjusted foot operated brake(back wheel) <b>44.3</b> |
| <input type="checkbox"/> Adjusted accelerator handle <b>44.4</b>                | <input type="checkbox"/> Adjusted manual transmission and clutch <b>44.5</b>   | <input type="checkbox"/> Adjusted rear view mirror(s) <b>44.6</b>             |
| <input type="checkbox"/> Adjusted commands (lights, indicators etc) <b>44.7</b> | <input type="checkbox"/> Seat height- allows driver, In a seated position, to have contact with the ground <b>44.8</b> | <input type="checkbox"/> Only with sidecar <b>45</b>                          |

**Please tick the relevant box**

- |  |   |
|--|---|
| <input type="checkbox"/> My licences is not enclosed because:<br>..... | <input type="checkbox"/> My licence is enclosed                             |
|  | <input type="checkbox"/> My licence has been returned to the<br>to the DVLA |

**Declaration:**I confirm that I **need** the controls I have indicated

Signature \_\_\_\_\_ Date \_\_\_\_\_

**You can get advice on special controls from the following****Website: [www.direct.gov.uk/diableddrivers](http://www.direct.gov.uk/diableddrivers)****And the Forum of Disabled Drivers Assessment Centres on 0800 559 36 36 (this telephone number is NOT for DVLA enquiries)**

|      |     |     |
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## CONSENT

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.

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 Doctor(s)** YES ☐ NO ☐

### Electronic Release of Information

DVLA is able to request and receive medical information by fax and email from you, your doctor(s) or any relevant personnel associated with your medical enquiry

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 we are unable to communicate in this way, conventional postage methods will be used instead. You must confirm in writing if you wish to cancel the agreement to communicate electronically.

Do you agree to DVLA communicating with you by fax and / or email YES ☐ NO ☐

Do you agree to DVLA communicating with your Doctors, Orthoptists or relevant personnel by fax and / or e-mail? YES ☐ NO ☐

|      |     |     |
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| NAME | DOB | REF |
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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 1DF

**By fax**

0845 850 0095

**By Email**

DVLA will always treat the information you send with the strictest confidence. However, as the security of the internet cannot be guaranteed, DVLA will be unable to send e-mails which contain personal information and advise that you also follow this policy.

If you feel at all concerned about emailing, please use another form of contact, e.g. post.

**Email address**

[eftd@dvla.gsi.gov.uk](mailto:eftd@dvla.gsi.gov.uk)

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

**Go to:** [www.direct.gov.uk/onlinemotoringservices](http://www.direct.gov.uk/onlinemotoringservices)

