# 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:

**Consultants Name and Address**

Title:

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 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 seen |
|---|---|---|
| | | |
| | | |
| | | |

**C1V ONLINE**
*(Rev Sept 10)*

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 |
|---|---|---|
| | | |

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) Does your medical condition affect your ability to control your Group 1 vehicle (Car or Motorcycle) safely at all times? | ☐ | ☐ |
| b) Does your medical condition affect your ability to control your Group 2 vehicle (Lorry, Bus Medium Sized Vehicles over 3500kG and Minibuses) safely at all times? | ☐ | ☐ |

**If your answered Yes to Question 8 and/or 8b please go to Question 8c.**
**If you answered No to both, please go to Question 9**

c) Do you or will you, as a result of your medical condition, drive a vehicle fitted with:

| | YES | NO |
|---|---|---|
| (i) special adaptations? | ☐ | ☐ |
| (ii) automatic transmission? | ☐ | ☐ |

**WHAT YOU NEED TO DO NEXT IF YOU HAVE ANSWERED YES TO QUESTION 8**

If you hold a full driving licence, please complete Section A on the attached D497 form and return it along with the questionnaire and your current driving licence (if you have not already done so).

**You can get advice on special adaptations from THE FORUM on 0800 559 3636**
**www.direct.gov.uk/disableddrivers**

**If you hold provisional driving entitlement or are applying for a provisional licence you DO NOT need to complete the D497**

| | YES | NO |
|---|---|---|
| 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.

| | 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***

- ☐ Automatic Transmission **78** (do not tick if driven by choice)
- ☐ Modified Transmission **10**
- ☐ Modified Clutch **15**
- ☐ Modified Braking System **20**
- ☐ Modified Control Layouts **35** (e.g. lights, switches, wipers)
- ☐ Modified Steering **40** (only tick if to overcome a disability)
- ☐ Modified Rear View Mirror **42**
- ☐ Modified Driver Seat **43**
- ☐ Modified Accelerator System **25**
- ☐ Combined Braking & Accelerator System **30**

### D497 – Motorcycle Controls

- ☐ Single Operated Brake **44.1**
- ☐ Adjusted hand operated brake (front wheel) **44.2**
- ☐ Adjusted foot operated brake(back wheel) **44.3**
- ☐ Adjusted accelerator handle **44.4**
- ☐ Adjusted manual transmission and clutch **44.5**
- ☐ Adjusted rear view mirror(s) **44.6**
- ☐ Adjusted commands (lights, indicators etc) **44.7**
- ☐ Seat height- allows driver, In a seated position, to have contact with the ground **44.8**
- ☐ Only with sidecar **45**

### Please tick the relevant box

- ☐ My licences is not enclosed because: ----------
- ☐ My licence is enclosed
- ☐ My licence has been returned 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**
**And the Forum of Disabled Drivers Assessment Centres on 0800 559 36 36 (this telephone number is NOT for DVLA enquiries)**

| NAME | DOB | REF |
|---|---|---|

# 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** | ☐ |

| 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 1DF

**By fax**

0845 850 0095

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

**Go to:** www.direct.gov.uk/onlinemotoringservices