

**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 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"/>

NAME	DOB	REF
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## Questionnaire to assess your medical fitness to drive

**M1V ONLINE**  
(Rev Aug 09)

If you are unsure of the answers, it would be advisable to discuss the form with your Mental Health Doctor or Nurse

1. Please give the name of your medical condition or conditions. \_\_\_\_\_  
\_\_\_\_\_
2. Please give the name and dosage(the amount you take) of all the current medication prescribed to you for the above conditions:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
3. Does the medication make you drowsy or confused **throughout** the day? YES ☐ NO ☐
4. In the past 12 months, have you regularly misused alcohol or illicit drugs? YES ☐ NO ☐  
If YES, please give brief details: \_\_\_\_\_  
\_\_\_\_\_
5. In the past 3 years, have you needed treatment for alcohol or drug dependency? YES ☐ NO ☐  
If YES, please give brief details: \_\_\_\_\_  
\_\_\_\_\_
6. Do you have serious memory problems or episodes of confusion? YES ☐ NO ☐
7. In the past 12 months, have you needed to be admitted or referred to a hospital or clinic for psychiatric treatment? YES ☐ NO ☐  
If YES, please give the dates and details: \_\_\_\_\_  
\_\_\_\_\_
8. In the past 12 months, have you suffered any fit(s), seizures or blackouts? YES ☐ NO ☐  
If YES, please give the dates and details. \_\_\_\_\_  
\_\_\_\_\_

NAME	DOB	REF
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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 ☐

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

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

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

