Confidential medical information

V1 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 last seen

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Eyesight

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

Please answer **ALL** questions:

1. Can you read a number plate from 20 metres and can you confirm that you have never been advised by an optician or doctor that your eyesight does not meet the minimum standards for driving? YES ☐ NO ☐

2. Do you need to wear glasses or contact lenses when you are driving? YES ☐ NO ☐

3. Do you have any of the following from questions 3a – f, affecting either eye? YES ☐ NO ☐

   If **YES**, please tick appropriate box(es) below

		Left Eye	Right Eye
a)	Glaucoma	☐	☐
b)	Treatment using eye drops for any condition (*Do not include ocular lubricants or tear replacement therapy) please state condition at question 10.*	☐	☐
c)	Cataracts or any Corneal Dystrophies e.g. Fuchs? (*Do not tick if you have had successful surgery to remove cataracts)*	☐	☐
d)	Macular Degeneration or any other Macular Disease	☐	☐
e)	Retinitis Pigmentosa	☐	☐
f)	Laser treatment or injections into both eyes (or remaining eye if one eye only) for diabetic eye disease or another eye condition?	☐	☐

	MM	YY
If **YES**, please give the date of your last laser treatment	☐	☐

4. Do you have a reduction or loss in your field of vision? YES ☐ NO ☐
   (Do not include long or short sightedness)

5. Are you registered as blind or partially sighted? YES ☐ NO ☐

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

	Left Eye	Right Eye
a) If **YES,** which eye is affected?	☐	☐

NAME	DOB	REF

7. Do you have double vision (diplopia)? YES ☐ NO ☐

   a) If **YES**, do you ensure any double vision is suppressed or controlled when driving? YES ☐ NO ☐

   b) Please tick in the box below how the double vision is controlled

   Patch ☐ Glasses/Lenses ☐ Prism ☐ Other ☐

   If you have ticked "Other" please specify _____

8. Do you have any other medical condition not specified at question 3 affecting either eye? YES ☐ NO ☐

a) If **YES**, please give details _____

9. Have you had cataracts removed? YES ☐ NO ☐

   If **YES**, please give date of surgery Left ☐ ☐

   Right ☐ ☐

10. Please give details of ALL medication taken by you including eye drops

Medication	Dosage	Reason for Taking

If you have answered YES to Q3c or 3d and the condition is in both eyes and you have had your eyes Tested within the last 6 months please take the visual acuity certificate to your optician to complete. If You have answered YES but have NOT had your eyes tested within the last 6 months, DO NOT ask your optician to complete the cert.

If you have answered NO to 3c or 3d and you ask your optician to complete the visual certificate we will NOT make payment to the optician. If you have answered NO please do not return the opticians certificate.

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VISUAL ACUITY CERTIFICATE

FOR THE OPTOMETRIST: IMPORTANT INFORMATION

Your patient has informed us that they currently have cataracts, maculopathy or any other macular disease and have had their eyes tested in the last 6 months. Please fill in this visual acuity certificate from their records. **You need not examine the patient**.

YOU WILL NOT BE PAID if you complete the form and your patient does not have any of the above conditions or the information you supply is more than 6 months old.

- Please provide the visual acuties using the 6 metre Snellen chart

Uncorrected acuities		**Corrected acuities** *(using the prescription currently worn for driving)*	
RIGHT EYE	**LEFT EYE**	**RIGHT EYE**	**LEFT EYE**

- Please give the best binocular acuity with corrective lenses if worn for driving. ☐

- Please give the date of the eye test

DD	**MM**	**YY**

- Please indicate (✓) the scale you have used to express the driver's visual acuitiess

Snellen ☐ **Snellen expressed as a decimal** ☐ **LogMAR** ☐

- Signature: _____

- Date: _____ Tel No: _____

- GMC, GOC, HPC No: _____ Renewal Date: _____

On receipt a fee of £11.50 will be paid by DVLA – if you are VAT registered we will pay the fee and VAT a the standard rate on receipt of an invoice

Opticians Stamp

- Please enter the payee name below:

_____

	Yes	**No**
Is there an invoice to follow?	☐	☐
Is there a VAT invoice to follow?	☐	☐

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