



**MEDICAL FITNESS TO DRIVE**

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Please answer the questions on this form in **BLOCK CAPITAL** letters using **BLACK INK**.  
If you do not answer all the questions the form will be returned to you and cause a delay.

**PART A: ABOUT YOU**

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Title:   
(Mr, Mrs, Miss, Other?)

Surname:

First Name(s):

Date of Birth: 

<b>DD</b>	<b>MM</b>	<b>YY</b>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Driver's No: 

<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"/>	<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"/>	<input type="text"/>	<input type="text"/>
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Address: 

<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"/>

Telephone No: 

Home	<input type="text"/>
Mobile	<input type="text"/>

  
(Including dialling code)

Email Address:

**PART B: ABOUT YOUR GP**

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Surname: 

Dr	<input type="text"/>
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First Name:

Surgery Address: 

<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"/>

Telephone No:   
(Including dialling code)

Date last seen: 

DD	MM	YY
<input type="text"/>	<input type="text"/>	<input type="text"/>

  
(For this condition)

NAME	DOB	REF
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**PART C: ABOUT THE CONSULTANT YOU SEE FOR THIS CONDITION**

Surname:   
(Including title)

First Name:

Hospital Department:

Hospital Address:   
  
  
Postcode

Telephone No:   
(Including dialling code)

Your Hospital No:

Date last seen:  DD  MM  YY

**\*If you have more than one Consultant please give their name & address on a separate sheet.\***

**PART D: DETAILS OF CLINICS ATTENDING / ATTENDED**

Clinics	Reason for attendance	Date last seen by			Date last seen by		
		GP			Consultant		
		DD	MM	YY	DD	MM	YY
Alcohol	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Cancer	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Cardiac	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Diabetes	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Drugs	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Neurological	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Psychiatry	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Sleep	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Vision	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other clinic	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

(Please give details below)

\_\_\_\_\_

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

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

	<b>Yes</b>	<b>No</b>		<b>DD</b>	<b>MM</b>	<b>YY</b>
a) Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	Date of diagnosis	<input type="text"/>	<input type="text"/>	<input type="text"/>
b) Have you had a relapse or relapses?	<input type="checkbox"/>	<input type="checkbox"/>	Date of relapse	<input type="text"/>	<input type="text"/>	<input type="text"/>
			Date of relapse	<input type="text"/>	<input type="text"/>	<input type="text"/>
			Date of relapse	<input type="text"/>	<input type="text"/>	<input type="text"/>
2. a) Motor Neurone Disease	<input type="checkbox"/>	<input type="checkbox"/>	Date of diagnosis	<input type="text"/>	<input type="text"/>	<input type="text"/>
b) Huntington's Disease	<input type="checkbox"/>	<input type="checkbox"/>	Date of diagnosis	<input type="text"/>	<input type="text"/>	<input type="text"/>
c) Other condition	<input type="checkbox"/>	<input type="checkbox"/>	Please give details	_____		

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

	<b>Doctor</b>			<b>Consultant</b>		
Date of last appointment	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Date of next appointment	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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

<b>Name of Medication</b>	<b>Dosage</b>	<b>Reason for taking</b>

4a Does the medication you take 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**

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**CN1 ONLINE**

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: \_\_\_\_\_

\_\_\_\_\_

8. Do you continue to have visual problems in both eyes?  
(such as your visual field, double vision) YES  NO

If YES, please give details of how your eyesight is affected? \_\_\_\_\_

\_\_\_\_\_

9. Does your medical condition affect your ability to control your  
vehicle safely? YES  NO

If you have answered YES to this question, please answer 9a

9a Do you (or will you) as a result of your medical condition, drive a vehicle fitted with

Special controls YES  NO

Automatic Transmission YES  NO

If YES, only fill in the enclosed form D497 if you hold a full driving licence

**You can get advice on special controls from THE FORUM Tel No. 0800 559 3636  
[www.direct.gov.uk/disableddrivers](http://www.direct.gov.uk/disableddrivers)**

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**INFORMATION ABOUT SPECIAL CONTROLS**

If you have said that you need special controls or automatic transmission, you must now fill in this D497 form and tell us what controls you need. You will also need to return both parts of your current driving licence if you have not already done so.

You can get advice on special controls from the website [www.direct.gov.uk/disableddrivers](http://www.direct.gov.uk/disableddrivers) and The Forum of Disabled Drivers' Assessment Centres on **0800 559 3636**

**YOU NEED ONLY FILL IN THE D497 IF YOU HOLD A FULL DRIVING LICENCE**

**Important Note for Provisional Applications or Licences**

If you hold provisional driving entitlement or are applying for a provisional licence you **DO NOT** need to fill in the D497 form at this time. If you need special controls the specific codes will be updated when you pass your driving test.

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**SPECIAL VEHICLE CONTROLS** (for cars, buses and lorries)

Please tick the relevant box(es)

- Automatic transmission (78)   
(Do **NOT** select this option if you drive automatic vehicles through choice)
- Modified transmission (gearbox) (10)
- Modified clutch (15)
- Modified braking system (20)
- Modified accelerator system (25)
- Combined braking and accelerator systems (30)
- Modified control layouts (e.g. lights, switches, wipers) (35)
- Modified steering (If power steering is essential to help overcome a disability please tick this box) (40)
- Modified rear view mirror(s) (42)
- Modified driver seat (43)

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**SPECIAL CONTROLS FOR MOTORCYCLES**

Please tick the relevant box(es)

- 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 (indicators, braking lights etc) (44 7)
- Seat height allowing the driver, in sitting position, to have 2 feet on the road at the same time (44 8)
- Only with sidecar (45)

*The number in brackets is the E.C. code which will appear on your licence. Please write to us if your circumstances change. We can change or remove codes.*

Please tick the relevant box.

- My current licence is enclosed
- My current licence has been sent to DVLA
- My current licence is not enclosed

Please explain why \_\_\_\_\_

**DECLARATION**

I confirm that I need the controls which I have indicated.

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

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# CONSENT

Rev Jul 07

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, and to inform my Doctor(s) of the outcome of the case where appropriate.

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: \_\_\_\_\_

#### Electronic Release of Information

DVLA is able to communicate by fax and by e-mail. We can use it to request medical information from your doctor(s). We can also use it to receive relevant medical information sent by your Doctors, Orthoptists or relevant personnel associated with any medical enquiry, medical examination or practical assessment that may be required.

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 you do not wish DVLA to communicate in this way or if we are unable to do so, conventional postage methods will be used instead. Should you wish to withdraw your agreement to communicate electronically by fax or e-mail at a later date such a request should be made by you in writing.

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

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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)