Driver & Vehicle Licensing Agency

Confidential medical information

V1 ONLINE
Rev Sept 14

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: *(if known)*

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:

Department:

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, department 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 & Department	Reason for attendance	Date last seen

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VISION MEDICAL QUESTIONNAIRE

V1 ONLINE
Rev Oct 17

1 Your Vision Condition(s)

1.1 What is your vision condition?

Tick all that apply

- ☐ Ocular Hypertension
- ☐ Macular Degeneration/Disease
- ☐ Glaucoma
- ☐ Corneal Graft
- ☐ Retinitis Pigmentosa
- ☐ Detached Retina
- ☐ Corneal Degeneration
- ☐ Central Vein Occlusion
- ☐ Double Vision (Diplopia)
- ☐ Corneal Dystrophy
- ☐ Cataracts (not removed)
- ☐ Nystagmus (including congenital)
- ☐ Hyphaemia
- ☐ Blepharospasm
- ☐ Other vision condition(s): _____

1.2 How many functioning eyes do you have?

A functioning eye is one that you have any sight in

- ☐ One
- ☐ Two

1.3 Which eyes does your condition affect?

- ☐ Both eyes
- ☐ Left eye
- ☐ Right eye

1.4 Have you ever had laser treatment or injections for an eye condition?

Do not include surgery for long/short sightedness or cataracts

- ☐ No ➔ **Go to 2**
- ☐ Yes, in one eye
- ☐ Yes, in both eyes

1.5 If yes, have you told us about your most recent laser treatment or injections?

- ☐ **Yes**
- ☐ **No**

NAME:	DOB:	REF:
DRIVER NUMBER:		

2 Field of Vision

2.1 Have you been told by a consultant or eye specialist that you have a problem with your field of vision?

Do not include long/short sightedness

☐ Yes ☐ No ➔ **Go to 3**

2.2 If yes, is your visual field problem caused solely by an eye condition?

☐ Yes ➔ **Go to 3** ☐ No

2.3 If no, is your visual problem caused by any of the following?

☐ Brain tumour ☐ Head injury

☐ Stroke ☐ Other

3 Double Vision (diplopia)

Only answer this section if you have Double Vision (diplopia)

3.1 How is your double vision (diplopia) controlled?

☐ Patch / Prism / Frosted glasses / Lenses ☐ Other ☐ Not controlled

3.2 Have you ever seen an eye specialist about your double vision (diplopia)?

☐ Yes ☐ No

3.3 Have you seen an eye specialist about your double vision (diplopia) in the last 12 months?

☐ Yes ☐ No

3.4 Confirm that you have read and understood the following information on double vision

Double Vision Information

It can take 3 months or more for you to adapt to driving wearing a patch, prism, frosted glasses or lenses because:

- Your ability to judge distances may be affected
- You may not be so aware of objects each side of you

You should not drive until you have been advised by your doctor or optician that you have fully adapted to wearing a patch, prism, frosted glasses or lenses.

☐ I have double vision and confirm that I have read and understood the above (tick)

4 Eyesight Standard

4.1 Can you meet the legal eyesight standard for driving?

The Legal Eyesight Standard for Driving

- You must be able to read a car number plate from 20 metres
- You must not have been told by a doctor or optician that your eyesight is currently worse than 6 /12 (decimal 0.5) on the Snellen scale

☐ Yes, with glasses or corrective lenses ☐ Yes ☐ No

Driver & Vehicle Licensing Agency

CONSENT

Consent to the release of medical information

IMPORTANT: Please read the following information carefully and sign and date the statement below and return this consent form with your questionnaire. We cannot proceed with enquiries into your fitness to drive until we receive both your completed questionnaire and consent form

- We have asked you for your consent for the release of medical reports from your doctors as we may require further information.
- As 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, Paramedical Staff or officers of the Secretary of State. Only information relevant to the assessment of your fitness to drive will be released.
- 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.

This section must NOT be altered in any way.

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 personal and medical information as may be necessary to the investigation of my fitness to drive, to Doctors, Orthoptists, Paramedical staff or Officers of the Secretary of State.

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 my medical information, and any other relevant information, to my doctor(s) by postal or electronic (fax or email) channels **Yes** ☐ **No** ☐

If you would like to be contacted about your application by email or Text message (SMS), please tick the appropriate boxes (below). If not, DVLA will continue to contact you by post.

I authorise a representative of the Secretary of State to contact me via Email or SMS Text in relation to this application (Please Tick): Email ☐ **Yes** ☐ **No** **SMS (Text)** ☐ **Yes** ☐ **No**

If you tick either of these options, DVLA will contact you using an external service provider regarding this application only. Your email / mobile details will not passed on to any other Third Parties, or used for marketing purposes.

NAME:	DOB:	REF:
DRIVER NUMBER:		

Driver & Vehicle Licensing Agency

Note: please fill in and return all pages (1-5) of this medical questionnaire and consent/declaration. If you do not give us all the information we need including the full name, address and telephone number of your GP/Consultant then there will be a delay with your case.

Please use the contact details below to return your filled in medical questionnaire to the Drivers Medical Group.

By Post

Drivers Medical Group
DVLA
Swansea
SA99 1DF

By fax

0300 083 0083

Please keep this page (6) for future reference.