Driver & Vehicle Licensing Agency

CN1

CN1
Rev May 24

IMPORTANT: Please answer the questions in **BLOCK CAPITAL** letters using **BLACK INK.**
Failure to provide full information for yourself, GP or consultant may result in your case being delayed.

PART A: About you

Current driving licence details

Title: _____ **Full name:** _____ **Date of birth:** _____

Address: _____

_____ **Postcode:** _____

Email: **Contact number:**

Change of details

If you have changed your contact information (address, name, email or contact number) since we last corresponded with you, please provide the NEW details in the box below.

PART B: Healthcare professional for **your condition**

GP details

GP name:

Surgery name:

Address:

Town:

Postcode:

Contact number:

Email:

Date last seen for this condition:

Consultant details

Consultant name:

Speciality: Department:

Hospital name:

Address:

Town:

Postcode:

Contact number:

Email:

Date last seen for this condition:

Driver & Vehicle Licensing Agency

Medical questionnaire – chronic neurological

CN1
Rev Nov 21

If you are unsure of the answers, we advise you to discuss this form with your healthcare professional

1. Please tick the appropriate boxes if you have suffered from any of the following conditions:

		Yes	No		DD	MM	YY
a)	Multiple sclerosis	☐	☐	Date of diagnosis			
b)	Have you had a relapse or relapses?	☐	☐	Date of relapse			
				Date of relapse			
				Date of relapse			
2. a)	Motor neurone disease	☐	☐	Date of diagnosis			
b)	Huntington's disease	☐	☐	Date of diagnosis			
c)	Peripheral neuropathy	☐	☐	Date of diagnosis			
d)	Myasthenia gravis	☐	☐	Date of diagnosis			
e)	Charcot-Marie-Tooth disease	☐	☐	Date of diagnosis			
f)	Other condition	☐	☐	Please give details			

_____

_____

3. Please supply the dates below of any phone, video or face to face consultations for this condition.

	DOCTOR			**CONSULTANT**		
	DD	MM	YY	DD	MM	YY
Date of last contact						
Date of next contact						

4. Has your doctor advised you that your condition has become worse in the last 3 years? Yes ☐ No ☐

5. Please give the name and dosage (the amount you take) of all medication you currently take

NAME OF MEDICATION	DOSAGE	REASON FOR TAKING

CN1

5a Does the medication you take make you drowsy or confused when driving? Yes ☐ No ☐

6. Do you need help from another person with your day to day living? Yes ☐ No ☐

If yes to Q6, please continue to 6a/b. If no to Q6, go to 7.

6a Do you rely on another person for remembering to attend appointments or take required medication? Yes ☐ No ☐

6b Do you rely on others or require help to operate household appliances, for example, a washing machine or cooker? Yes ☐ No ☐

7. Has your doctor or family/friends expressed any concerns in regards to your driving? Yes ☐ No ☐

8. Has your condition caused any problems with your eyesight? Yes ☐ No ☐
If yes, please tick below. **Do not include long or short sightedness** **If no, go to Q11**

Optic neuritis: ☐ **If yes, go to Q9**

Double vision (diplopia): ☐ **If yes, go to Q10**

Other: ☐ If other provide details below

If other, please give details of how your eyesight is affected _____

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9. Optic neuritis:
If you have experienced an episode of optic neuritis, has that condition now resolved? Yes ☐ No ☐

10. Double vision (diplopia)
If you have double vision (diplopia), how is your double vision (diplopia) controlled?

Patch ☐ Medication ☐ Other ☐

Prism/frosted glasses/lenses ☐ Not controlled ☐

10a You must confirm that you've read and understood the following information on double vision.

Information: double vision

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 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)

CN1

11. Have you already had an on-road driving assessment? Yes ☐ No ☐
If yes, please provide a copy of the driving assessment report.

12. As a result of your medical condition, do you need to drive a vehicle with automatic gears? Yes ☐ No ☐

13. As a result of your medical condition, do you need to drive a vehicle with special controls? Yes ☐ No ☐

If no, go to the declaration on the next page. If yes, please indicate what controls you need.

13a Select any modifications that you need to drive a car.

Modified transmission *(10)* ☐	Modified clutch *(15)* ☐	Modified braking system *(20)* ☐
Modified accelerator system *(25)* ☐	Pedal adaptations and pedal safeguards *(31)* ☐	Combined service brake and accelerator systems *(32)* ☐
Combined service brake, accelerator and steering systems *(33)* ☐	Modified control layouts *(35)* ☐	Modified steering *(40)* ☐
Modified rear view mirror *(42)* ☐	Modified driver seat *(43)* ☐	

13b Select any modifications that you need to drive a motorcycle, moped or tricycle

Single operated brake *(44.01)* ☐	Adapted front wheel brake *(44.02)* ☐	Adapted rear wheel brake *(44.03)* ☐
Adjusted accelerator *(44.04)* ☐	Adjusted manual transmission and clutch *(44.05)* ☐	Adjusted rear view mirror *(44.06)* ☐
Adjusted commands *(for example; lights or indicators) (44.07)* ☐	Seat height *(allows the driver to have 2 feet on the surface at once and balance the wheel when stopping /standing) (44.08)* ☐	Adapted foot-rest *(44.11)* ☐
Adapted hand grip *(44.12)* ☐	Motorcycle with sidecar only *(45)* ☐	

CN1

Applicant's Declaration

You **must** fill in this section and must **not** alter it in any way. Please read the following information carefully and sign to confirm the statements below.

I understand that it is a criminal offence to make a false declaration to get a driving licence and that to do so can lead to prosecution and a maximum penalty of up to 2 years imprisonment.

Please read the following statements:

- I agree to follow the advice of my doctor(s) about treatment for this/these condition(s)
- I will attend, where necessary, appointments to monitor my condition(s)
- I will inform DVLA should I become aware my condition gets worse
- I will inform DVLA if I develop any other medical condition which may impact my ability to drive safely

Do you agree to abide by the above statements? Yes ☐ No ☐

I confirm that the answers I have given within the medical questionnaire are true.

I also agree that I will inform you if any of the information provided changes.

Name (print) _____

Signature _____ Date ☐☐☐

Driver & Vehicle Licensing Agency

Applicant's authorisation

You **must** fill in this section and must **not** alter it in any way. Please read the following information carefully and sign to confirm the statements below.

Important information about fitness to drive

- As part of the investigation into your fitness to drive, we (DVLA) may require you to have a medical examination and/or some form of practical assessment. If we do, the individuals involved in these will need your background medical details to carry out an appropriate assessment.
- These individuals may include doctors, orthoptists at eye clinics or paramedical staff at a driving assessment centre. We will only share information relevant to the medical assessment of your fitness to drive.
- Also, where the circumstances of your case appear to suggest the need for this, the relevant medical information may need to be considered by one or more of the members of the Secretary of State's Honorary Medical Advisory Panels. The membership of these Panels conforms strictly to the principle of confidentiality.

For information about how we process your data, your rights and who to contact, see our privacy notice at www.gov.uk/dvla/privacy-policy

This section must NOT be altered in any way.

Declaration

I authorise my doctor, specialist or appropriate healthcare professional to disclose medical information or reports about my health condition to DVLA, on behalf of the Secretary of State for Transport, that is relevant to my fitness to drive.

I understand that the doctor that I authorise may pass this authorisation to another registered healthcare professional, who will be able to provide information about my medical condition that is relevant to my fitness to drive.

I understand that the Secretary of State may disclose such relevant medical information as is necessary to the investigation of my fitness to drive to doctors and other healthcare professionals such as orthoptists, paramedical staff and the Secretary of State for Transport's Honorary Medical Advisory 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 correspond with medical professionals by email. **Yes** ☐ **No** ☐

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

If you would like to be contacted about your application by email or text message (SMS) by a healthcare professional acting on behalf of DVLA, please tick the appropriate boxes. If not, you'll be contacted by post.

Email ☐ **SMS (text)** ☐

Driver & Vehicle Licensing Agency

Note: there will be a delay with your case if you do not give us all the information we need, including the full name, address and telephone number of your healthcare professional.

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 email:

eftd@dvla.gov.uk

Please keep this page for future reference.