



Confidential Medical Information Neurological Developmental Conditions

Form A1 ODL
Online Version - Feb 25

Medical Fitness to Drive

Please answer all questions on this form in BLOCK CAPITAL letters using BLACK INK

1 YOUR DETAILS:

Title		Surname		Date of birth	
First name(s)		Driver Number			
Address		Telephone Number(s)			
		Home			
		Mobile			
Postcode		Email			

2 YOUR DOCTOR AND YOUR CONSULTANT:

If you have more than one consultant, please give their name, department and address on a separate sheet.

Doctor's Name and Address		Consultant's Name and Address	
Name		Title	
Postcode		Postcode	
Tel		Tel	
Date last seen by Doctor (for this condition)		Date last seen by Consultant (for this condition)	

Doctor's email address (if known)

Consultant's email address (if known)

Hospital number (if known)

3 OTHER CLINICS:

Please provide details of any other clinics you are attending

Name of clinic & Department	Reason for attendance	Date last seen



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Please note that you only need to complete ALL sections of this form if you think your condition(s) may affect your ability to drive safely

1 Please confirm the condition(s) you been diagnosed with below (tick all that apply)

Attention Deficit Hyperactivity Disorder (ADHD)

☐

Attention Deficit Disorder (ADD)

☐

Autism Spectrum Condition (ASC)

☐

Other Neurological Developmental Condition

☐

Please specify

Do you think your condition(s) may affect your ability to drive safely?

Yes

☐

No

☐

If you have answered 'Yes' please continue to Section 2 below.

If you have answered 'No' please skip forward to Section 6 on the next page.

2 Please identify the healthcare professional who supports you with your condition.

Consultant

☐

GP

☐

Other

☐

(please specify below)

Please provide us with the name and address of the healthcare professional who supports you in the space below. If there is more than one, please provide their details on a separate page:

Name:

Address:

Phone number:

Email:

Date you last saw them

DD

MM

YYYY

Name:

Date of Birth:

Driver Number:

3 Are you taking any medication for this condition?

Yes

☐

No

☐

4 Please give the name and dosage of all the prescribed medication that you take and the reason you take it.

Medication	Dosage	Reason for taking

5 (a) In the past 5 years have you had any fits or seizures?

Yes

☐

No

☐

(b) In the past 5 years, have you had any blackouts?

Yes

☐

No

☐

6 Do you have any other medical condition that you need to tell us about?

Yes

☐

No

☐

If YES, please specify

If you have answered 'No' to both of the questions in Section 1 and Section 6 then it is not necessary for you to submit an A1 form to DVA. Please note in this scenario you are also not required to declare your condition on your DL1 application form. You only need to tell DVA if you feel your condition may make you an unsafe driver OR if you are prescribed medication that causes side effects that will affect your driving.

Please return this form, including the consent declaration on the next page, to:

Driver and Vehicle Agency
Driver Licensing Medical Section
County Hall
Castlerock Road
Coleraine
BT51 3TB

Name:

Date of Birth:

Driver Number:



CONSENT TO THE RELEASE OF MEDICAL INFORMATION

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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. DVA cannot proceed with enquiries into your fitness to drive until your completed questionnaire and consent have been received.

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, DVA may require you to undergo a medical examination or some form of practical assessment.

In these circumstances, those personnel involved will require your relevant 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 DVA 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 Department and its medical advisors.

I authorise the Department and its medical advisors 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: _____