Driver & Vehicle Licensing Agency

Confidential medical information

B1 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)*

NHS 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

Questionnaire to assess your medical fitness to drive

If you are unsure of the answers we advise you to discuss this form with your doctor

1. Please tick the appropriate box(es) if you have ever had any of the following:

a. Brain tumour (including cysts & pituitary tumours) ☐ Date ☐☐☐☐
Please give details _____

b. Brain haemorrhage (including subarachnoid, aneurysm & AVM) ☐ Date ☐☐☐☐
Please give details _____

c. Severe head injury involving in-patient treatment ☐ Date ☐☐☐☐
Please give details _____

d. Any other condition ☐ Date ☐☐☐☐
If ticked, please give details _____

e. Please give date of any brain surgery Not applicable ☐ Date ☐☐☐☐

2. Who did you last see for the treatment of this condition GP ☐ Consultant ☐

a. Please provide the following dates:

	GP	Consultant
Date of last appointment	☐☐☐☐	☐☐☐☐
Date of next appointment	☐☐☐☐	☐☐☐☐

3. Have you ever had a blackout(s)/altered level of consciousness? Yes ☐ No ☐

If Yes, please give the date Date ☐☐☐☐

4. Have you ever had any form of seizures/epileptic attacks? Yes ☐ No ☐

If Yes, please indicate the diagnosis (tick the relevant box), if No. Go to Q7

Epileptic attacks are variably described and involve fits, convulsions or seizures. Epilepsy may also occur only as auras strange feelings or taste, absences or blank spells, limb jerking or twitching. Epileptic episodes may occur when asleep or when awake

First ever seizure *(Go to Q5)* ☐

More than one seizure ever or epilepsy? *(Go to Q6)* ☐

5. First ever seizure

Please provide the date of the seizure Date ☐☐☐☐

Please give details: _____

_____

_____

6. More than one seizure ever or epilepsy

Please provide the following dates

		Awake		Asleep	
a)	First awake seizure		b)	First asleep seizure	
c)	Last 2 awake seizures		d)	Last 2 asleep seizures	

e) If you have had both awake and sleep attacks, please give the date of the first sleep attack after the last awake attack. Date

f) Have you ever had two or more seizures within a 5 year period? Yes ☐ No ☐

g) Have your seizures ever affected your level of consciousness? Yes ☐ No ☐

If Yes, please go to Q6h, if No go to Q6i

h) Would your seizures ever have caused difficulty controlling a vehicle? Yes ☐ No ☐

If No to Q6i or if yes, please give a full description of the attack

_____

_____

i) Was your last seizure a result of advice from your doctor to either stop, reduce or change your epilepsy medication? Yes ☐ No ☐

If No to Q6i go to Q6j, if Yes please answer the following questions.

(i) Please give the date you started to reduce/change your medication Date

(ii) Has the previously effective medication been restarted? Yes ☐ No ☐

(iii) Please give the date the previously effective medication was restarted. Date

(iv) Please give the date of your last seizure prior to the medication withdrawal or reduction of medication seizure. Date

j) If you have been advised by a doctor that your seizure was provoked, please provide details of the circumstances of the seizure and provoking factor

_____

_____

Declaration

This declaration needs to be signed if you have had a diagnosis of epilepsy or had more than one seizure.

I agree to

- follow the advice of my doctor(s) about treatment for this condition
- attend where necessary, appointments to monitor my condition
- inform DVLA should I experience any further attacks

Signed: _____ Date: _____

NAME:	DOB:	REF:
DRIVER NUMBER:		

7. Please give the name of any medication that you take/have taken — No medication taken ☐

Name of medication	Start date	End date

a) Does your medication make you drowsy or confused when driving? Yes ☐ No ☐

8. Have you ever had an insertion or upper end revision of a VP shunt or external ventricular drain? Yes ☐ No ☐

If Yes, please give the date — Date ☐☐☐☐☐☐

9. 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 _____

_____

_____

10. Do you have double vision (diplopia)? Yes ☐ No ☐

If Yes, please answer the following questions.
If No, go to Q11.

a) Do you ensure your double vision is suppressed or controlled? Yes ☐ No ☐

b) If **Yes**, how do you ensure your double vision is suppressed or controlled while driving? Patch ☐ Glasses/lenses ☐ Prism ☐ Other ☐

If "other" please give details: _____

11. Has your condition caused problems with your eyesight? Yes ☐ No ☐

If Yes, please give details: _____

12. Do you need to drive a vehicle fitted with special controls or automatic transsmission? *If you answered No to Q12 you DO NOT need to answer Q12a and Q12b.* Yes ☐ No ☐

a) Have you told us before that you need special controls or automatic transmission? *If Yes, please answer Q12b.* Yes ☐ No ☐

b) Since your last licence was issued, have you had any additional controls fitted to your vehicle? Yes ☐ No ☐

If you have any relevant hospital notes about your medical condition, please send copies with this form.

Driver & Vehicle Licensing Agency

Applicants 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/

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 release information relevant to the medical assessment of your fitness.
- 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.

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.

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 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, orthoptists, 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 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**

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.