Driver & Vehicle Licensing Agency

Confidential medical information

STR1V 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: Telephone Number(s):

Home

Mobile

Postcode Email

PART B: ABOUT YOUR GP AND YOUR CONSULTANT

GP's Name and Address

Dr:

Postcode:

TEL No: *(Including dialling code)*

Consultants Name and Address

Title:

Department:

Postcode:

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

Driver & Vehicle Licensing Agency

STR1V ONLINE
Rev Jan 18

Questionnaire to assess your medical fitness to drive

1. Have you suffered a TIA? Yes ☐ No ☐ *Date* ☐☐☐☐☐☐

a) Have you had multiple TIA's? Yes ☐ No ☐

If Yes, please provide dates of the most recent TIA's.

DD	MM	YY	DD	MM	YY	DD	MM	YY

b) Do you have any residual problems? Yes ☐ No ☐

2. Have you suffered a stroke? Yes ☐ No ☐ ***Date*** ☐☐☐☐☐☐

a) Have you had multiple strokes? Yes ☐ No ☐

b) Do you have any residual problems? Yes ☐ No ☐

c) Are you able to walk at a brisk pace for 9 minutes? Yes ☐ No ☐

If No, please give the reason why _____

3. Please give the date of your last and next appointment with your doctor and/or consultant (*for this condition)*

	Doctor			Consultant		
	DD	**MM**	**YY**	**DD**	**MM**	**YY**
Date of last appointment:						
Date of next appointment:						

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

Name of Medication	Dosage	Reason for taking

4a. Does your medication make you drowsy or confused when driving? Yes ☐ No ☐

5. Have you needed rehabilitation? Yes ☐ No ☐
(e.g. physiotherapy, speech therapy or occupational therapy)

If Yes, please give details of ongoing treatment _____

NAME:	DOB:	REF:
DRIVER NUMBER:		

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

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

7. Have you ever had any form of seizure? Yes ☐ No ☐
If you have answered No to this question please go to Q10, If Yes, please indicate the diagnosis

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 – ***If you tick this go to Q9*** ☐

More than one seizure ever or epilepsy – ***If you tick this go to Q10*** ☐

8. **First ever seizure** – Please provide the date of the seizure ***Date*** ☐☐☐☐☐☐

Please give details _____

_____

_____

9. **More than one seizure ever or epilepsy** – Please provide the following dates:

		AWAKE					**SLEEP**		
a)	First awake seizure	☐☐	☐☐	☐☐	b)	First sleep seizure	☐☐	☐☐	☐☐
c)	Last 2 awake seizures	☐☐	☐☐	☐☐	d)	Last 2 sleep seizures	☐☐	☐☐	☐☐
		☐☐	☐☐	☐☐			☐☐	☐☐	☐☐

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

f) Are you currently on anti-epileptic medication? Yes ☐ No ☐

g) If no longer treated, please give the date treatment stopped. ***Date*** ☐☐☐☐☐☐

h) Have your seizures **ever** affected your level of consciousness? Yes ☐ No ☐
If Yes, please go to Q10i, and if No, go to Q10j

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

If No to Q10h or Q10i, please give a full description of the attack _____

_____

_____

j) Was your last seizure a result of advice from your doctor to either stop reduce or change your medication? Yes ☐ No ☐
If No go to 10k. 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 epilepsy 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*** ☐☐☐☐☐☐

k) If you have been advised by a doctor that your seizure was provoked, please provide full details of the circumstances of the seizure and the 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 my treatment for epilepsy.
- attend where necessary, appointments to monitor my condition.
- inform DVLA should I experience any further attacks

Signature _____ Date _____

10. Have you been advised by a healthcare professional that you have memory loss problems, episodes of confusion or difficulty with concentrating that affects safe driving? Yes ☐ No ☐

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

If Yes, please give the details of how they help you _____

_____

_____

12. Has your condition caused problems with your eyesight? Yes ☐ No ☐
(Such as your visual field, double vision)

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

_____

_____

13. Do you **need** to drive a Group 1 vehicle fitted with special controls or automatic transmission? Yes ☐ No ☐

a) Do you **need** to drive a Group 2 vehicle fitted with special controls or automatic transmission? Yes ☐ No ☐

b) Have you told us before that your need special controls or automatic transmission? Yes ☐ No ☐

c) Since your last licence was issued have you had any addition controls fitted to your vehicle? Yes ☐ No ☐

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.