Driver & Vehicle Licensing Agency

Confidential medical information

FEP1V 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)*

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

Driver & Vehicle Licensing Agency

Questionnaire to assess your medical fitness to drive

FEP1V ONLINE
Rev Feb 17

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.

PART D: About your medical condition

Question 1 **Please indicate diagnosis** (tick relevant box):

a) First ever seizure ☐
Go to Question 2

b) More than one seizure ever or epilepsy ☐
Go to Question 3

c) Non-epileptic attack disorder, dissociative seizures or pseudoseizures ☐
Go to Question 4

d) Blackout(s) or altered level of consciousness ☐
Go to Question 6

Question 2 **First ever seizure**

Date of seizure Date ☐☐☐

Please give details _____

_____

_____

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

_____

_____

Now go to Question 5 over the page

Question 3 **More than one seizure ever or epilepsy**

Please provide the following dates

		Awake		Sleep	
a)	First awake seizure	☐☐☐	b)	First sleep seizure	☐☐☐
c)	Last two awake seizures	☐☐☐	d)	Last two 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 ☐☐☐

NAME:	DOB:	REF:
DRIVER NUMBER:		

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

g) If no longer treated, please give date when treatment ended Date ☐☐ ☐☐ ☐☐

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

If Yes, please go to Q3i, If No, please go to Q3j

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

If NO to both Q3h or Q3i please give a full description of attack

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

If you have answered No to Q3j go to Q5

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

(ii) Has 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 ☐☐ ☐☐ ☐☐

Question 4 Non-epileptic attack disorder, dissociative seizures or pseudoseizures

a) Please give date of last event Date ☐☐ ☐☐ ☐☐

b) Have any of the events happened while driving or as a passenger in a vehicle? Yes ☐ No ☐

Question 5

a) Have you had a seizure as a result of alcohol misuse? Yes ☐ No ☐

If Yes, please give the date(s) and details Date ☐☐ ☐☐ ☐☐

b) Have you had a seizure as a result of illicit drug misuse? Yes ☐ No ☐

If Yes, please give the date(s) and details Date ☐☐ ☐☐ ☐☐

Go to declaration on next page

Declaration
This declaration needs to be signed if you have had more than one seizure whether or not a diagnosis of epilepsy has been made.

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

Signature: _____ Date: _____

Question 6 Blackout(s) or altered level of consciousness

		First Event	Last Event
a)	Date(s) of blackout/altered level of consciousness	Date	
b)	Have you had a pacemaker fitted?	Yes ☐	No ☐
c)	Have you had an ICD defibrillator fitted as a result of a blackout?	Yes ☐	No ☐
	If Yes to Q6C, please give date device was fitted	Date	

Question 7

a) Please name all medications you take/have taken for this condition

Medication name	Date started	Date stopped

b) Does the medication make you drowsy or confused whilst driving? Yes ☐ No ☐

Question 8

Please give the date of your last and next appointment with your Doctor or Consultant for this condition

	Doctor	Consultant
Last appointment		
Next appointment		

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 medical information, discovered during the investigation into my fitness to drive, to my Doctor(s) **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.