Driver & Vehicle Licensing Agency

Confidential medical information

STR1 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

NAME:	DOB:	REF:
DRIVER NUMBER:		

Driver & Vehicle Licensing Agency

STR1 ONLINE
Rev Feb 19

Questionnaire to assess your medical fitness to drive

Reminder: You must not drive for at least 1 month from the date of your Transient Ischaemic Attack (TIA) / last TIA.

1. Have you suffered a single TIA? Yes ☐ No ☐

1a. If Yes, have you had any residual problems? Yes ☐ No ☐

If you have answered Yes to Question 1 and No to Question 1a do not fill in the rest of the form. Please return the form using the envelope provided

2. Have you suffered multiple TIA's Yes ☐ No ☐

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

DD	MM	YY	DD	MM	YY	DD	MM	YY

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

3a. One month after your stroke are there any residual problems causing weakness or visual disturbance, or any problems with co-ordination, memory or understanding? Yes ☐ No ☐

3b. Have your doctors expressed any concerns about your fitness to drive? Yes ☐ No ☐

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

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

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

Name of Medication	Dosage	Reason for taking

5a. Does your medication make you drowsy or confused when driving? Yes ☐ No ☐

6. Have you needed rehabilitation ? Yes ☐ No ☐
(for example, physiotherapy, speech therapy or occupational therapy)

If Yes please give details of ongoing treatment _____

NAME:	DOB:	REF:
DRIVER NUMBER:		

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

If Yes, please give the date Date ☐☐☐

8. Have you ever had any form of seizures or epileptic attacks? Yes ☐ No ☐
If you have answered No to this question please go to Q11
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

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

Please give details: _____

_____

_____

10. 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 seizure			

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) Have your seizures <u>ever</u> affected your level of consciousness? Yes ☐ No ☐
If Yes, please go to Q10h, and if No, go to Q10g

g) Would your seizures have ever caused difficulty controlling a vehicle? Yes ☐ No ☐
If No, to Q10h or Q10g, please give a full description of the attack

_____

_____

h) Was your last seizure a result of advice from your Doctor to either stop, or change your medication? Yes ☐ No ☐
If No to Q10h go to Q10j. 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 ☐☐☐

j) 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 treatment for this condition.
- attend where necessary, appointments to monitor my condition.
- inform DVLA should I experience any further attacks

Signature _____ Date _____

11. 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 _____

_____

_____

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

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

_____

_____

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

14. Do you have any persisting limb problems where you need to drive a vehicle fitted with special controls or automatic transmission? *If you answered No to **Q14** you Do not need to answer **Q14a** and **Q14b**.* Yes ☐ No ☐

a) Have you told us before that you need special controls or automatic transmission? *If you answered Yes to **Q14a** please answer **Q14b*** Yes ☐ No ☐

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

NAME:	DOB:	REF:
DRIVER NUMBER:		

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.