Driver & Vehicle Licensing Agency

Confidential medical information

DIAB1 ONLINE

Rev Sept 14

PART A: ABOUT YOU

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

Title: ______ Surname: ______ Date of Birth: ______
(Mr, Mrs, Miss, Other?)

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	Consultants Name and Address
Dr:	Title:
	Department:
Postcode:	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

DIABETES MEDICAL QUESTIONNAIRE

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1 Your Diabetes

1.1 How is your diabetes treated?

Insulin ☐ Tablets or non-insulin injectable ☐

1.2 Do you agree to monitor your glucose/sugar levels at times relevant to driving?

* Times relevant to driving means testing less than 2 hours before the start of a journey, and every 2 hours after driving has commenced. A maximum of 2 hours should pass between the pre-driving glucose check and the first glucose check after driving has commenced.

(!) This is a legal requirement for drivers with insulin treated diabetes

Yes ☐ No ☐

1.3 Confirm that you understand the symptoms of low blood sugar (hypoglycaemia)

Symptoms of low blood sugar (hypoglycaemia)

As a driver with diabetes, you need to know the symptoms of low blood sugar:

- hunger
- shakiness
- sleepiness
- nervousness
- confusion
- sweating
- weakness
- difficulty speaking
- anxiety
- dizziness or light-headedness

Low blood sugar can also happen during sleep. Some examples are:

- crying out or having nightmares
- damp sheets or pyjamas from perspiration
- feeling tired, irritable or confused after waking

I confirm that I have read and understood the symptoms above (tick) ☐

1.4 Have you ever had an episode of low blood sugar (hypoglycaemia) whilst awake?

Yes ☐ No ☐ ➔ **Go to 2**

1.5 If yes, do you get warning symptoms of low blood sugar (hypoglycaemia)?

Warning symptoms will make you aware of when an episode of low blood sugar is occurring

Yes ☐ No ☐

1.6 How many episodes of low blood sugar (hypoglycaemia) have you had whilst awake in the last 12 months?

None ☐ ➔ **Go to 2** One ☐ ➔ **Go to 2** Two (or more) ☐

NAME:	DOB:	REF:

DRIVER NUMBER:

1.7 | If two (or more), when having these episodes of low blood sugar, did you need help from another person?

Do not count episodes where you were given help but could have helped yourself

Yes, I needed help both times (or more) ☐ ➔ **Go to 1.8**

I only needed help once ☐ ➔ **Go to 2**

No, I didn't need help ☐ ➔ **Go to 2**

1.8 | Were any of these episodes within the last 3 months?

Yes ☐

No ☐ ➔ **Go to 2**

2 Your Healthcare Professional

2.1 | Who should we contact if we need to investigate further?

GP / GP Nurse ☐

Consultant / Nurse Specialist at hospital clinic ☐

2.2 | Have you seen your healthcare professional about your diabetes in the last 12 months?

Yes ☐

No ☐

3 Your Eyesight

3.1 | Can you meet the legal eyesight standard for driving?

The Legal Eyesight Standards for Driving

- You must be able to read a car number plate from 20 metres.
- You have been told by an optician that your eyesight is currently 6/12 (decimal 0.5) or better on the standard optician's eyesight chart (Snellen scale).

(!) *If you are unsure if you can meet the eyesight standards contact your optician for advice.*

Yes, **without** glasses or corrective lenses ☐

Yes, **with** glasses or corrective lenses ☐

No ☐

NAME:	DOB:	REF:
DRIVER NUMBER:		

3.2 How many functioning eyes do you have?

A functioning eye is one that you have any sight in

One ☐ Two ☐

3.3 Have you ever had laser treatment or injections for diabetic eye disease?

Do not include surgery for long/short sightedness

No ☐ ➔ **Go to 3.5** | Yes, in one eye ☐ ➔ **Go to 3.5** | Yes, in both eyes ☐

3.4 If yes, have you told us about your most recent injections or laser treatment?

Yes ☐ No ☐

3.5 Have you been advised by a healthcare professional that you have a visual field defect?

Yes ☐ No ☐

NAME:	DOB:	REF:
DRIVER NUMBER:		

4 Special Controls

4.1 As a result of your medical condition, do you have to drive a vehicle with automatic gears?

Yes ☐ No ☐

4.2 As a result of your medical condition, do you need to drive a vehicle with special controls?

Yes ☐ ➔ **Go to 4.3** No ☐

If No to 4.2, 4.3 & 4.4 do not need to be answered

4.3 Select any modifications that you need to drive a car

Modified transmission *(10)*	☐	Modified clutch *(15)*	☐	Modified braking system *(20)*	☐
Modified accelerator system *(25)*	☐	Pedal adaptations and pedal safeguards *(31)*	☐	Combined service brake and accelerator systems *(32)*	☐
Combined service brake, accelerator and steering systems *(33)*	☐	Modified control layouts *(35)*	☐	Modified steering *(40)*	☐
Modified rear view mirror *(42)*	☐	Modified driver seat *(43)*	☐		

4.4 Select any modifications that you need to drive a motorcycle, moped or tricycle

Single operated brake *(44.01)*	☐	Adapted front wheel brake *(44.02)*	☐	Adapted rear wheel brake *(44.03)*	☐
Adjusted accelerator *(44.04)*	☐	Adjusted manual transmission and clutch *(44.05)*	☐	Adjusted rear view mirror *(44.06)*	☐
Adjusted commands *(light, indicators etc.) (44.07)*	☐	Seat height *(allows the driver to have two feet on the surface at once and balance the wheel when stopping /standing) (44.08)*	☐	Adapted foot rest *(44.11)*	☐
Adapted hand grip *(44.12)*	☐	Motorcycle with sidecar only *(45)*	☐		

If you have ticked any of the above you will need to return your driving licence with this completed form

NAME:	DOB:	REF:
DRIVER NUMBER:		

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 (1-6) 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 (7) for future reference.

Find out about DVLA's online services

Go to: www.gov.uk/browse/driving