Driver & Vehicle Licensing Agency

Confidential medical information

B 1 V

B1V
Rev Jul 22

PART A: ABOUT YOU

Please complete this form in **BLOCK CAPITAL** letters using **BLACK INK**

Title _____ Full name _____

Full address _____

_____

Postcode _____ Date of birth _____

NHS number _____ Driver number _____
(If known)

Mobile number _____ Home number _____
(Optional) *(Optional)*

Email _____
(Optional)

PART B: HEALTHCARE PROFESSIONAL DETAILS

Please provide the details of the GP and Consultant you have seen for this condition
IMPORTANT: You must provide their full name and address, or the form will be returned to you, delaying your application

GP DETAILS

Full name _____

Surgery _____

Full address _____

_____

Postcode _____ Phone number _____

Email _____
(If known)

Date last seen by GP for this condition _____

CONSULTANT DETAILS

Title _____ Full name _____

Department _____

Full hospital address _____

_____

_____

Postcode _____ Phone number _____

Email _____
(If known)

Date last seen by consultant for this condition _____

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Medical questionnaire – neurological – vocational

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Rev May 2023

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

   b) Severe head injury involving in-patient treatment ☐ Date ☐☐☐☐☐☐
   Please give details _____

   c) Any other condition ☐ Date ☐☐☐☐☐☐
   If ticked, please give details _____

   d) 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 supply the dates below of any phone, video or face to face consultations for this condition

	GP	**Consultant**
Date of last contact	☐☐☐☐☐☐	☐☐☐☐☐☐
Date of next contact	☐☐☐☐☐☐	☐☐☐☐☐☐

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

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

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

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

5. Have you ever had any form of seizures or epileptic attacks? Yes ☐ No ☐
   If no, please go to Q8

   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 Q6

   More than 1 seizure ever or epilepsy ☐
   If you tick this go to Q7

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6. First ever seizure

Please provide the date of the seizure Date

Please give details: _____

_____

_____

7. More than 1 seizure ever or epilepsy

a) Have you ever had 2 or more seizures in a 5 year period? Yes ☐ No ☐

Please provide the following dates

		Awake					Sleep		
b)	First awake seizure				c)	First sleep seizure			
d)	Last 2 awake seizures				e)	Last 2 sleep seizures			

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

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

h) If no longer treated, please give the date the treatment stopped Date

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

If yes, please go to Q7j, if no, go to Q7k

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

If no to Q7i or Q7j, please give a full description of the attack.

_____

_____

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

If you have answered no to Q7k go to Q7l

(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

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l) 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

_____

_____

_____

Please complete the declaration below if appropriate

Declaration

This declaration needs to be signed if you have had a diagnosis of epilepsy or had more than 1 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 the DVLA should I experience any further attacks

Signed: _____ Date: _____

8. Please give the name of any medication that you take or 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 ☐

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 no, please go to Q11

If yes, please answer the following questions

a) Is your double vision suppressed or controlled? Yes ☐ No ☐

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

If "Other" please give details _____

_____

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

If yes, please name the condition and how it affects you _____

_____

12. Do you need to drive a vehicle fitted with special controls or automatic transmission for cars and motorcycles (Group 1 vehicles) or buses and lorries (Group 2 vehicles)? Yes ☐ No ☐

If yes, please indicate Group 1 ☐ Group 2 ☐

a) Have you told us before that you need special controls or automatic transmission? 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

Applicant's authorisation

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 share information relevant to the medical assessment of your fitness to drive.
- 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.

For information about how we process your data, your rights and who to contact, see our privacy notice at www.gov.uk/dvla/privacy-policy

This section must NOT be altered in any way.

Declaration

I authorise my doctor, specialist or appropriate healthcare professional to disclose medical information or reports about my health condition to the DVLA, on behalf of the Secretary of State for Transport, that is relevant to my fitness to drive.

I understand that the doctor that I authorise, may pass this authorisation to another registered healthcare professional, who will be able to provide information about my medical condition that is relevant to my fitness to drive.

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 and other healthcare professionals such as orthoptists, paramedical staff and the Secretary of State for Transport's Honorary Medical Advisory 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 correspond with medical professionals by email **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**

Driver & Vehicle Licensing Agency

Note: please complete and return all pages of this medical questionnaire and authorisation form. 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 completed medical questionnaire to the **Drivers Medical Group**

By Post:

Drivers Medical Group,
DVLA,
Swansea.
SA99 1DF

Email: eftd@dvla.gov.uk

Please keep this page for future reference