Driver & Vehicle Licensing Agency

Confidential medical information

VOCH1

VOCH1
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 OR consultant you have seen for this condition
IMPORTANT: You must provide the full name and address of your GP and/or consultant. The form will be returned to you resulting in delays.

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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1. Please indicate what type of heart or other cardiovascular problems you have and date of diagnosis or treatment (tick ✓ relevant box).

		✓		Date
a)	Angina	☐	*Last attack*	☐☐ ☐☐ ☐☐
b)	Heart attack *(Myocardial Infarction)* or acute coronary syndrome	☐		☐☐ ☐☐ ☐☐
c)	Angioplasty/stent	☐	*Most recent procedure*	☐☐ ☐☐ ☐☐
d)	Heart by-pass surgery *(CABG)*	☐		☐☐ ☐☐ ☐☐
e)	Abnormal heart rhythm *(Arrhythmia)*	☐	*Most recent episode*	☐☐ ☐☐ ☐☐
	Has your condition caused any sudden and disabling giddiness or fainting within the last 12 months?		Yes ☐	No ☐
	Has the condition been controlled?		Yes ☐	No ☐
f)	Pacemaker *(If you have a pacemaker you must also sign and date the "VPACE" declaration on page 3).*	☐	*Date implanted*	☐☐ ☐☐ ☐☐
	Are you now free of the symptoms that caused the device to be fitted?		Yes ☐	No ☐
g)	Catheter ablation	☐	*Most recent procedure*	☐☐ ☐☐ ☐☐
	Was your ablation for a sudden disabling event?		Yes ☐	No ☐
h)	Defibrillator	☐	*Date implanted*	☐☐ ☐☐ ☐☐

Note:* Q1(i) to 1(n) & Q1(p) *Please give date of last contact (Any phone, video or face to face consultation for this condition)

i)	Peripheral arterial vascular disease	☐	*See note above*	☐☐ ☐☐ ☐☐
j)	Aortic aneurysm	☐	*See note above*	☐☐ ☐☐ ☐☐
	Please confirm the most recent measurement of your aneurysm *(if known)*			☐☐☐ cm
k)	Aortic dissection	☐	*See note above*	☐☐ ☐☐ ☐☐
l)	Heart failure	☐	*See note above*	☐☐ ☐☐ ☐☐
	Are you suffering from symptoms that would affect safe driving? *e.g. shortness of breath, chest pains, palpatations etc*		Yes ☐	No ☐
m)	Brugada syndrome	☐	*See note above*	☐☐ ☐☐ ☐☐
n)	Long QT syndrome	☐	*See note above*	☐☐ ☐☐ ☐☐

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		✓	Date
o)	High blood pressure *(Hypertension)*		
	Is it well controlled? (C*onsistently under 180/100 mm/Hg)*	Yes	No
	Please confirm your latest blood pressure reading *(if known)*		/
p)	Malignant hypertension		*See note above Q1(i)*
q)	Has a special pacemaker been implanted to improve your heart failure? *(CRT-P)*		*Date implanted*

(If you have a pacemaker you must also sign and date the "VPACE" declaration on page 3).

r)	Has a cardiac assist device (LVAD) been implanted?		*Date implanted*

What is the device? _____

s) Any other heart condition? Please give details. _____

_____

2. If required, would you be able to walk at a brisk pace for 9 minutes? Yes ☐ No ☐

If No, please give the reason why? _____

_____

3. Please give details of your current medication:

Name of medication	Dosage	Reason for taking

4. Please state your current Height ☐ Weight ☐

5. Please indicate the type of cardiac investigations or procedures you have undergone or are waiting for,please tick ✓ the relevant box(es):

		✓	Date
a)	Exercise test or treadmill test		

Did you stop any medication 48 hours prior to the test Yes ☐ No ☐

If Yes, what medication was stopped? _____

Do you know how long you exercised for to the nearest minute? _____

		✓			
b)	Myocardial perfusion scan/Stress echo				
c)	Coronary angiography				
d)	Echocardiogram				
e)	Other				

If Other, please give details: _____

_____

6. Do you have any other medical condition? Yes ☐ No ☐

If Yes, please give details: _____

_____

If you have answered Yes to Q1f – Read and sign the VPACE declaration

Conditions of a vocational driving licence.

1. Regular pacemaker checks under the care of a consultant cardiologist are undertaken.

2. The advice of the doctor/cardiologist concerning your treatment and medical review is followed for the duration of your licence.

3. You undertake to notify DVLA if you suffer any sudden attacks of disabling giddiness/fainting or blackouts or any other medical condition which may affect safe driving.

4. Your licence does not require regular review for any other medical condition.

Pacemaker Declaration:

"I have a pacemaker implanted and I agree to comply with the above conditions if I am issued with an ordinary (Group 1) and vocational (Group 2) driving licence"

Signature: _____ Date: _____

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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 healthcare professionals via electronic channels (fax or 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**

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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

By Fax:

0300 083 0083

Electronically – Email:

eftd@dvla.gov.uk

Please keep this page for future reference.