Driver & Vehicle Licensing Agency

Confidential medical information

STR1

STR1
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: Failure to provide your GP/Consultant's full information will result in your case being delayed.

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 _____

Driver & Vehicle Licensing Agency

Medical questionnaire – stroke / transient ischaemic attack

STR1
Rev Oct 23

If you are unsure of the answers, we advise you to discuss this form with your doctor.

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

1. Have you had a Stroke/TIA? Yes ☐ No ☐ Date ☐☐/☐☐/☐☐☐☐

a) One month after your stroke, are there any residual problems? Yes ☐ No ☐

b) Do you have cognitive, co-ordination, memory or understanding issues? Yes ☐ No ☐

c) Do you have limb weakness or sensory loss? Yes ☐ No ☐

d) Do you have vision problems? Yes ☐ No ☐
If yes, please tick the relevant box

i) Visual field loss ☐

ii) Visual inattention ☐
As diagnosed by your consultant (not visual field loss)

iii) Double vision ☐

If yes to double vision, how is it controlled?

Patch/Prism/Frosted glasses or lenses ☐ Other ☐ Not controlled ☐

Double Vision Declaration

It can take 3 months or more for you to adapt to driving wearing a patch, prism, frosted glasses or lenses because:

- your ability to judge distances may be affected
- you may not be aware of objects each side of you

You should not drive until you have been advised by your doctor or optician that you have fully adapted to wearing a patch, prism, frosted glasses or lenses.

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

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

If yes, please give the date of your last therapy session. Date ☐☐/☐☐/☐☐

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

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

STR1

5. Have you ever had any form of seizure(s)/epileptic seizures? Yes ☐ No ☐
If no, go to Q9

Epileptic seizures 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 seizures may occur when asleep or when awake

6. First ever seizure, please provide the date of the seizure Date ☐☐☐☐☐☐

If you have had more than 1 seizure ever or diagnosed with epilepsy, please answer the following:

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

	Awake		Sleep	
a)	First awake seizure	☐☐☐☐☐☐	b) First sleep seizure	☐☐☐☐☐☐
c)	Last 2 awake seizures	☐☐☐☐☐☐	d) Last 2 sleep seizures	☐☐☐☐☐☐
	*	☐☐☐☐☐☐		☐☐☐☐☐☐

e) If you have had both awake and sleep seizures, please give the date of the first sleep seizure after the last awake seizure. * Date ☐☐☐☐☐☐

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

g) Have your seizures ever caused difficulty controlling a vehicle? Yes ☐ No ☐

8. If you have been advised by a doctor that your seizure was a provoked or an acute symptomatic seizure, please provide full details of the circumstances of the seizure and the provoking factor.

_____

_____

_____

_____

Epilepsy 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, when necessary, appointments to monitor my condition
- inform DVLA should I experience any further seizures

Signature _____ Date _____

9. Have you had an on-road driving assessment? Yes ☐ No ☐

If yes, please provide the date you attended on your on road driving assessment. *Please provide a copy of the driving assessment report* Date ☐☐☐☐☐☐

STR1

10. Do you have any persisting limb problems where you need to drive a vehicle fitted with special controls or automatic transmission? Yes ☐ No ☐
If you answered no to Q10 you do not need to answer Q10a and Q10b

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 ☐

c) 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)* ☐	

d) 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 2 feet on the surface at once and balance the wheel when stopping /standing) (44.08)* ☐	Adapted footrest *(44.11)* ☐
Adapted hand grip *(44.12)* ☐	Motorcycle with sidecar only *(45)* ☐	

Driver & Vehicle Licensing Agency

Rev July 22

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