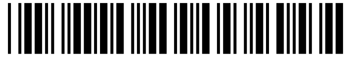
Driver & Vehicle Licensing Agency

Confidential medical information



STR1V
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 ______________

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Medical questionnaire – stroke / transient ischaemic attack – vocational

STR1V
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If you are unsure of the answers, we advise you to discuss this form with your doctor.

1. Have you had a single or multiple:

   TIA? Single ☐ Multiple ☐

   Stroke? Single ☐ Multiple ☐

   Please provide date(s) of the most recent TIA/stroke

   ☐☐☐ ☐☐☐ ☐☐☐

2. One month after the event(s), are there any residual problems? Yes ☐ No ☐

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

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

   c) Do you have vision problems? Yes ☐ No ☐

      i) Visual field loss ☐

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

      iii) Double vision ☐

   If double vision (diplopia), how is it controlled?

   Patch or glasses with frosted lens ☐ Glasses with prism ☐ Other ☐ Not controlled ☐

3. Please give the name(s) and the amount (dosage) of all the current medication you take.

Medication	Dosage	Reason for taking

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

STR1V

4. Are you able to walk at a brisk pace for 9 minutes? Yes ☐ No ☐

   If no, please give the reason why. ____________________

   ____

   ____

5. Have you needed rehabilitation? Yes ☐ No ☐
   (e.g., physiotherapy, speech therapy, occupational therapy)

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

7. Have you ever had any form of seizure(s)/epileptic seizure(s)? Yes ☐ No ☐

   If yes, please indicate the diagnosis (tick the relevant box). **If no, go to Question 11**

   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

8. First ever seizure, please provide date of seizure ☐☐☐

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

9. Have you had 2 or more seizures within 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. * ☐☐☐

f) Have your seizures ever affected your level of consciousness? Yes ☐ No ☐
If yes, go to Q9g. If no, go to Q10

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

10. 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 ________________

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

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

12. Do you <u>**need**</u> to drive a Group 1 vehicle fitted with special controls or automatic transmission? Yes ☐ No ☐

    a) Do you <u>**need**</u> to drive a Group 2 vehicle fitted with special controls or automatic transmission? Yes ☐ No ☐

    If you answered no to Q12 or Q12a you do not need to answer Q12b and Q12c

    b) Have you told us before that you need special controls or automatic transmission? Yes ☐ No ☐

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

Please go to the next page to indicate any modifications you may need

d) **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)* ☐

e) **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)* ☐

f) **Select any modifications that you need to drive a lorry or bus.**

- 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)* ☐

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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 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

Find out about **DVLA's online services**

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