Driver & Vehicle Licensing Agency

Confidential medical information

DIAB1
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 – diabetes

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

1 Please tell us how your diabetes is treated. Put **X** in all boxes that apply.

a) Insulin ☐ **Go to Q2**

b) Sulphonylurea or Glinide (S&G) tablets ☐ **Go to Q3**

c) Any other treatment:

- tablets, such as Metformin or Dapagliflozin ☐
- non-insulin injections ☐
- pancreas transplant ☐
- islet cell transplant ☐
- diet or other lifestyle changes ☐

If ONLY boxes in 'c' are ticked go to Q8

If you are unsure what medication you are taking, you should discuss this with your doctor.

Below is a list of Sulphonylurea and Glinide – it is not an exhaustive list.

Sulphonylurea
- Tolbutamide
- Chlorpropamide
- Gliclazide also known as Zicron, Diamicron or Glydex
- Glipizide Modified Release also known as Dacadis MR, Diamicron MR, Edicil MR, Lamzarin MR, Nazdol, Ziclaseg MR, Laaglyda MR
- Glibenclamide also known as Amglidia or Euglucon
- Glipizide also known as Minodab
- Glimepiride also known as Amaryl

Glinide
- Repaglinide also known as Enyglid or Prandin
- Nateglinide also known as Starlix

2 Do you check your blood glucose (sugar) levels? Yes ☐ No ☐

3 Do you understand the warning signs of low blood glucose (hypoglycaemia)?

Yes ☐ No ☐ **For information on symptoms of low blood glucose see table below:**

Early warning signs of low blood glucose include:

- sweating
- anxiety
- shakiness or trembling
- fast pulse or palpitations
- feeling hungry
- tingling lips

If you don't treat this, it may result in more severe symptoms such as:

- slurred speech
- confusion
- difficulty concentrating
- disorderly or irrational behaviour which may be mistaken for drunkenness

If left untreated this may lead to unconsciousness

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4 Do you get warning signs of low blood glucose?

Never had episodes of low blood glucose	☐	**Go to Q7**

Yes, I get warning signs ☐ No, I don’t get warning signs ☐

Warning signs will make you aware of when an episode of low blood glucose is happening

5 Have you had any severe episodes of low blood glucose, whilst awake, in the last 12 months?

Yes ☐ | No ☐ **Go to Q7**

Severe means an episode of low blood glucose needing help from another person.

a) Were you driving when having a severe episode? Yes ☐ No ☐

b) If **yes**, tell us the date of this severe episode:

Day	Month	Year

6 Have you had 2 or more episodes of low blood glucose in the last 12 months where you needed help?

Yes ☐ | No ☐ **Go to Q7**

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

a) If **yes**, did any of these episodes happen in the last 3 months?

Yes ☐ No ☐

7 Do you agree to monitor your blood glucose levels at times relevant to driving?

Yes ☐ No ☐

8 Have you had any treatment for diabetic related issues affecting both eyes, or the remaining eye if you only have sight in one eye?
For example, laser treatment or eye surgery.

Yes ☐ | No ☐ **Go to Q9**

a) If **yes**, tell us the date of your last treatment:

Day	Month	Year

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9 As a result of your diabetes, do you have any problems with your limbs that affect your ability to control your vehicle safely?

Yes ☐ | No ☐ **If no, do not complete the rest of the form**

a) As a result of this condition, do you have to drive a vehicle with special controls?

Yes ☐ No ☐

b) If **yes,** please tell us of any modifications that you need to drive a car:

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

If **yes,** please tell us of 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) ☐

10 As a result of your health condition, have you been told that you can only drive a vehicle with automatic gears? Do not mark 'Yes' if you drive a vehicle with automatic gears by choice.

Yes ☐ No ☐

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**

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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

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