Driver & Vehicle Licensing Agency

Confidential medical information

FEP1V

FEP1V
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 – epilepsy / seizure / loss of consciousness – vocational

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

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.

Question 1 **Please indicate diagnosis** (tick relevant box):

a) First ever seizure ☐
Go to Question 2

b) More than one seizure ever or epilepsy ☐
Go to Question 3

c) Dissociative or functional seizures ☐
Go to Question 4

d) Blackout(s) or altered level of consciousness ☐
Go to Question 6

Question 2 **First ever seizure**

Date of seizure Date ☐☐☐

Please give details _____

_____

_____

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 go to Question 5 over the page

Question 3 **More than one 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 ☐☐☐

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

h) If no longer treated, please give date when treatment ended Date ☐☐☐

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

If yes, please go to Q3j. If no, please go to Q3k

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

If no to both Q3i or Q3j please give a full description of attack _____

_____

_____

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

If you have answered no to Q3k go to Q5

(i) Please give the date you started to reduce/change your medication. Date ☐☐☐

(ii) Has 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 ☐☐☐

Question 4 Dissociative or functional seizures

a) Please give date of last event Date ☐☐☐

b) Have any of the events happened while driving or as a passenger in a vehicle? Yes ☐ No ☐

Question 5

a) Have you had a seizure as a result of alcohol misuse? Yes ☐ No ☐

If yes, please give the date(s) and details Date ☐☐☐

_____

_____

b) Have you had a seizure as a result of illicit drug misuse? Yes ☐ No ☐

If yes, please give the date(s) and details Date ☐☐☐

_____

_____

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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 where necessary, appointments to monitor my condition
- inform DVLA should I experience any further attacks

Signature: _____ Date: _____

Question 6 Blackout(s) or altered level of consciousness

a) Date(s) of blackout/altered level of consciousness — First Event Date | | | | Last Event | | |

b) Have you had a pacemaker fitted? Yes ☐ No ☐

c) Have you had an ICD defibrillator fitted as a result of a blackout? Yes ☐ No ☐

If yes to Q6c, please give date device was fitted Date | | | |

Question 7

a) Please name all medications you take/have taken for this condition

Medication name	Date started	Date stopped

b) Does the medication make you drowsy or confused whilst driving? Yes ☐ No ☐

Question 8

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

	Doctor				Consultant		
Date of last contact				Date of last contact			
Date of next contact				Date of next contact			

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