Driver & Vehicle Licensing Agency

Confidential medical information

FEP1

FEP1
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

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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 1 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

a) Date of seizure *Date* ☐☐☐☐☐☐

Please give details _____

_____

_____

b) 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

Question 3 More than 1 seizure ever or epilepsy

a. Have you ever had 2 or more seizures in a 5 year period? Yes ☐ No ☐
If yes, please go to Q3b. If no, please go to Q3c

b. Was the first of these seizures within the last 12 months? Yes ☐ No ☐

c. Please provide the following dates

AWAKE SEIZURES	Day	Month	Year
First awake seizure			
Last 2 awake seizures			

SLEEP SEIZURES	Day	Month	Year
First sleep seizure			
Last 2 sleep seizures			

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Question 3 continued

d) If you have had both awake and sleep attacks, please give the date of the first sleep attack after the last awake attack

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

If yes, please go to Q3f. If no, please go to Q3g

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

If no to both Q3e or Q3f please give a full description of attack

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

If you have answered no to Q3g go to Q5

(i) If yes to Q3g, 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 previous 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 the date of last event *Date* ☐☐☐

b) Have any of the events happened whilst 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 drug misuse? Yes ☐ No ☐

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

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Question 6 Blackout(s) or altered level of consciousness

		First Event DD	First Event MM	First Event YY	Last Event DD	Last Event MM	Last Event YY
a)	Date(s) of blackout or altered level of consciousness						

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, please give the date the 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 next contact	☐☐☐	☐☐☐

Please turn over to read and sign the Applicant's Declaration

Applicant's Declaration

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.

I understand that it is a criminal offence to make a false declaration to get a driving licence and that to do so can lead to prosecution and a maximum penalty of up to 2 years imprisonment.

Please read the following statements:

- I must inform DVLA of any medical condition which may impact my ability to drive safely
- I agree to follow the advice of my doctor(s) about treatment for this/these condition(s)
- I will attend, where necessary, appointments to monitor my condition(s)
- I will inform DVLA should I become aware my condition gets worse or I experience any further seizures

Do you agree to abide by the above statements? Yes ☐ No ☐

I confirm that the answers I have given within the medical questionnaire are true. I also agree that I will inform you if any of the information provided changes.

Name _____

Signature _____ Date ☐☐☐

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