Driver & Vehicle Licensing Agency

Confidential medical information

PAH1V

PAH1V
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 _____

Driver & Vehicle Licensing Agency

Medical questionnaire – pulmonary arterial hypertension – vocational

PAH1V
Rev Oct 20

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

1. Please confirm you have a diagnosis of pulmonary arterial hypertension. Yes ☐ No ☐

a) If yes, please tick which hospital you attend and provide the name of the consultant.

Note: If you are attending a local clinic/hospital but have previously attended/due to attend one of the hospitals below please tick the hospital you previously attended/are due to attend.

Freeman Hospital, Newcastle	☐	Golden Jubilee Hospital, Glasgow	☐
Great Ormond St Hospital, London	☐	Hammersmith Hospital, London	☐
Papworth Hospital, Cambridgeshire	☐	Royal Brompton Hospital, London	☐
Royal Free Hospital, London	☐	Royal Hallamshire Hospital, Sheffield	☐

Consultant's name: _____

Please tick the box if you have **never been seen/not due to be seen** at any of the hospitals listed above. ☐

b) Please supply the date of your last contact with your consultant. (Any phone, video or face to face consultation for this condition)

DD	MM	YY

2. Have you been advised by your consultant that you should stop driving due to your condition? Yes ☐ No ☐

3. Do you have a history of collapse or blackouts (or feeling that you may blackout)? Yes ☐ No ☐ ***If no, go to Q4***

a) If yes, how many blackout(s) have you had? One ☐ More than One ☐

b) Please give the date of the most recent episode

DD	MM	YY

c) Was this due to pulmonary arterial hypertension or another condition?

Pulmonary arterial hypertension ☐ Another condition/explanation ☐ ***Please specify below***

_____

_____

d) If due to pulmonary arterial hypertension, since your blackout(s), have you received futher treatment to prevent these? Yes ☐ No ☐

If yes, please give details of the treatment below. _____

_____

_____

_____

4. Does the medication make you drowsy or confused while driving? Yes ☐ No ☐

Please list your medication. _____

_____

_____

_____

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