Driver & Vehicle Licensing Agency

STRV1

STR1V
Rev May 24

IMPORTANT: Please answer the questions in **BLOCK CAPITAL** letters using **BLACK INK.**
Failure to provide full information for yourself, GP or consultant may result in your case being delayed.

PART A: About you

Current driving licence details

Title: _____ **Full name:** _____ **Date of birth:** _____

Address: _____

_____ **Postcode:** _____

Email: **Contact number:**

Change of details

If you have changed your contact information (address, name, email or contact number) since we last corresponded with you, please provide the NEW details in the box below.

PART B: Healthcare professional for **your condition**

GP details

GP name:

Surgery name:

Address:

Town:

Postcode:

Contact number:

Email:

Date last seen for this condition:

Consultant details

Consultant name:

Speciality: Department:

Hospital name:

Address:

Town:

Postcode:

Contact number:

Email:

Date last seen for this condition:

Driver & Vehicle Licensing Agency

Medical questionnaire – stroke / transient ischaemic attack – vocational

STR1V
Rev Oct 23

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

DD	MM	YY	DD	MM	YY	DD	MM	YY

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.

NAME OF MEDICAITON	DOSAGE	REASON FOR TAKING

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

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 ☐
(For example, 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 no, go to Question 11

If yes, please indicate the diagnosis (tick the relevant box).

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 — DD ☐☐ MM ☐☐ YY ☐☐

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 DD MM YY		SLEEP DD MM YY
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***

DD MM YY ☐☐ ☐☐ ☐☐

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

a) Do you **need** 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 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)* ☐	

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 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

Electronically – Email:

eftd@dvla.gov.uk

Please keep this page for future reference