



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.

| |
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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:

When notifying DVLA of a heart condition it is important that you provide the correct name of any device you may have fitted. Providing DVLA with the wrong information can affect our decision about your driving licence.

Below is a list of the more common devices which may assist you when completing the questionnaire.

Pacemakers

A pacemaker is a small electrical device fitted in the chest or abdomen. It's used to treat some abnormal heart rhythms (arrhythmias) that can cause your heart to either beat too slowly or miss beats.

Implantable Cardioverter Defibrillator (ICD)

An ICD is a small electrical device that constantly monitors your heart rhythm through the electrodes and treats dangerous abnormal heart rhythms when they occur. An ICD is placed under the skin just below the collarbone to monitor your heart rate through thin wires connecting electrodes to your heart.

Cardiac resynchronisation therapy with a pacemaker (CRT-P)

Also known as bi-ventricular pacing. This treatment involves having a pacemaker with 3 leads called a bi-ventricular pacemaker. CRT-P can help your heart to pump more efficiently which can improve your symptoms. (Usually used in the treatment of heart failure).

Cardiac resynchronisation therapy with a defibrillator (CRT-D)

This treatment involves having a single device that combines a bi-ventricular (3-lead) pacemaker and an ICD. It's used for people with heart failure who might also be at risk of developing fast, life-threatening heart rhythms.

Ventricular assist device (VAD)

A VAD is a mechanical pump that helps pump blood from the heart to the rest of the body. It's a treatment for weakened heart or heart failure. Some pumps are meant for short-term support (a few days or weeks), whilst waiting for other treatments, such as heart transplant, while others can be used for longer periods of time/long-term treatment. If the device is intended to be used for a limited period, for example, whilst waiting for heart transplant, it's removed after the transplant or definitive treatment. Having a VAD fitted requires open-heart surgery.



Medical questionnaire – cardiac – vocational

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

1. Please indicate what type of heart or other cardiovascular problems you have and date of diagnosis or treatment (put X in the boxes that apply)

| | | | | | |
|---|--------------------------|--------------------------|----------------------|--------------------------|----------------------|
| a) Angina | <input type="checkbox"/> | Last attack | DD | MM | YY |
| | | | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| b) Heart attack (Myocardial Infarction) or Acute coronary syndrome | <input type="checkbox"/> | Last attack | DD | MM | YY |
| | | | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| c) Angioplasty/stent | <input type="checkbox"/> | Procedure date | DD | MM | YY |
| | | | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| d) Heart by-pass surgery (CABG) | <input type="checkbox"/> | Procedure date | DD | MM | YY |
| | | | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| e) Abnormal heart rhythm (arrhythmia) including atrial fibrillation | | | <input type="text"/> | | |
| • Has the above condition caused any sudden and disabling giddiness/fainting or blackout within the last 12 months? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | |
| • If yes, please provide date of latest episode | | | DD | MM | YY |
| | | | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| • If yes, has this been controlled? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | |
| f) Pacemaker | <input type="checkbox"/> | Date implanted | DD | MM | YY |
| | | | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Are you now free of the symptoms that caused the device to be fitted? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | |
| g) Cardiac Resynchronisation Therapy Pacemaker device (CRT-P) been implanted to improve heart failure? | <input type="checkbox"/> | Date implanted | DD | MM | YY |
| | | | <input type="text"/> | <input type="text"/> | <input type="text"/> |

If you have a pacemaker or CRT-P, proceed to the pacemaker declaration below.

You must confirm you've read and understood the following information.

As a driver with a pacemaker fitted, I agree to:

- attend regular pacemaker checks with my healthcare professional
- follow the advice of my healthcare professional about the treatment for my heart condition
- notify DVLA if I suffer any sudden attacks of disabling dizziness, fainting or blackouts

Put 'X' in the box if you agree with the following statement.

"I have a pacemaker implanted and I agree to comply with the above conditions if I am issued with a car or motorcycle (group 1) and lorry or bus (group 2) driving licence"

VOCH1

- h) Catheter ablation Procedure date

| | | |
|----|----|----|
| DD | MM | YY |
| | | |
- i) Defibrillator (ICD/CRT-D) Date implanted

| | | |
|----|----|----|
| DD | MM | YY |
| | | |
- j) Peripheral arterial vascular disease (PVD) Date last seen

| | | |
|----|----|----|
| DD | MM | YY |
| | | |
- k) Aortic aneurysm Date last seen

| | | |
|----|----|----|
| DD | MM | YY |
| | | |

Please confirm the most recent measurement of your aneurysm (if known)

Less than 4cm 4cm – 5.4cm 5.5cm or more Don't know

Has your aneurysm been repaired? Yes No

If you have have an aortic aneurysm proceed to the declaration below.

You must confirm you've read and understood the following information.

As a driver with an aortic aneurysm, I agree to:

- attend yearly imaging checks under the care of a consultant cardiologist
- follow the advice of my healthcare professional about the treatment for my medical condition
- notify DVLA if I develop any other health condition which may impact my ability to drive safely

Put 'X' in the box if you agree with the following statement.

"I have an aortic aneurysm and I agree to comply with the above conditions if I am issued with a car or motorcycle (group 1) and lorry or bus (group 2) driving licence"

- l) Aortic dissection Date last seen

| | | |
|----|----|----|
| DD | MM | YY |
| | | |
- m) Heart failure Date last seen

| | | |
|----|----|----|
| DD | MM | YY |
| | | |
- Are you suffering from symptoms that would affect safe driving? (E.g. shortness of breath, chest pains, palpitations) Yes No
- n) Has a cardiac assist device (VAD) been implanted? Date implanted

| | | |
|----|----|----|
| DD | MM | YY |
| | | |
- o) Hypertrophic cardiomyopathy Date last seen

| | | |
|----|----|----|
| DD | MM | YY |
| | | |
- p) Other cardiomyopathies Date last seen

| | | |
|----|----|----|
| DD | MM | YY |
| | | |

Please provide details: _____
- q) Brugada syndrome Date last seen

| | | |
|----|----|----|
| DD | MM | YY |
| | | |
- r) Long QT syndrome Date last seen

| | | |
|----|----|----|
| DD | MM | YY |
| | | |
- s) High blood pressure (Hypertension)
- Is it well controlled? (under 180/100 mmm/Hg) Yes No
 - Please confirm your latest blood pressure reading (if known)

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- t) Malignant hypertension Date last seen

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|----|----|----|
| DD | MM | YY |
| | | |

VOCH1

u) Any other heart condition(s)? Please provide details: _____

2. If required, would you be able to walk at brisk pace for 9 minutes? Yes Go to Q3 No

a) If no, please tell us why: _____

3. Please tell us your current Height Weight

4. Please indicate the type of cardiac investigations or procedures you have undergone or are waiting for, please put 'X' in boxes that apply and provide most recent date attended:

a) Coronary angiography

| | | |
|----------------------|----------------------|----------------------|
| DD | MM | YY |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |

b) Echocardiogram

| | | |
|----------------------|----------------------|----------------------|
| DD | MM | YY |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |

c) Exercise test or treadmill test

| | | |
|----------------------|----------------------|----------------------|
| DD | MM | YY |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |

Do you know how long you exercised for to the nearest minute? _____

d) Myocardial perfusion scan/stress echo/cardiac MRI

| | | |
|----------------------|----------------------|----------------------|
| DD | MM | YY |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |

e) Other

| | | |
|----------------------|----------------------|----------------------|
| DD | MM | YY |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |

If other, please tell us the details: _____



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



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



Find out about DVLA's online services

Go to: www.gov.uk/browse/driving

