



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:

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Contact number:

--	--	--	--	--	--	--	--	--	--	--	--

Email: _____
Date last seen for this condition:

--	--	--

Consultant details

Consultant name: _____
Speciality: _____ **Department:** _____
Hospital name: _____
Address: _____

Town: _____
Postcode:

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Contact number:

--	--	--	--	--	--	--	--	--	--	--	--

Email: _____
Date last seen for this condition:

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Medical questionnaire – pulmonary arterial hypertension

If you require assistance completing this form, please discuss with your healthcare professional

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 or are due to attend one of the hospitals below, please tick the hospital you previously attended/are due to attend.

Freeman Hospital, Newcastle	<input type="checkbox"/>	Golden Jubilee Hospital, Glasgow	<input type="checkbox"/>
Great Ormond St Hospital, London	<input type="checkbox"/>	Hammersmith Hospital, London	<input type="checkbox"/>
Papworth Hospital, Cambridgeshire	<input type="checkbox"/>	Royal Brompton Hospital, London	<input type="checkbox"/>
Royal Free Hospital, London	<input type="checkbox"/>	Royal Hallamshire Hospital, Sheffield	<input type="checkbox"/>

Consultant's name: _____

Please tick the box if you have **never been seen or are 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
<input type="text"/>	<input type="text"/>	<input type="text"/>

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 |
|----------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> |

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

Pulmonary arterial hypertension ☐ Another condition/explanation ☐
(Please specify below)

PAH1

- d) If due to pulmonary arterial hypertension, since your blackout(s), have you received further 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. _____



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. If not, DVLA will continue to contact you by post. Email ☐ SMS (text) ☐

If you would like to be contacted about your application by email or text message (SMS) by a healthcare professional acting on behalf of DVLA, please tick the appropriate boxes. If not, you'll be contacted by post.

Email ☐ SMS (text) ☐



Driver & Vehicle
Licensing
Agency

Note: there will be a delay with your case if you do not give us all the information we need, including the full name, address and telephone number of your healthcare professional.

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

By email:

eftd@dvla.gov.uk

Please keep this page for future reference.



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We invest in people Gold

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