Driver & Vehicle Licensing Agency

BT1

BT1
Rev Oct 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 personal 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:

Specialty: Department:

Hospital name:

Address:

Town:

Postcode:

Contact number:

Email:

Date last seen for this condition:

Driver & Vehicle Licensing Agency

Medical questionnaire – brain tumours

BT1
Rev May 23

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

1. Have you been diagnosed with a brain tumour? Yes ☐ No ☐

- Meningioma ☐
- Glioblastoma ☐
- Pituitary tumour ☐
- Metastatic disease ☐
- Other, please specify ☐ _____

2. When was the tumour diagnosed? DD MM YY

3. How has/is the tumour being managed:

		DD MM YY
Observation	☐	
Biopsy	☐	
Surgery	☐	
Radiotherapy, SRS, Gamma Knife, Proton Beam Therapy	☐	
Chemotherapy	☐	
Medication	☐	

Please provide the name of the medication _____

4. Please supply the dates below of any phone, video or face to face consultations for this condition.

	GP			CONSULTANT		
	DD	MM	YY	DD	MM	YY
Date of last contact						
Date of next contact						

5. Have you had a device fitted that relieves pressure on brain due to excess fluid? (for example, a VP shunt) Yes ☐ No ☐

If yes, please give the date DD MM YY

6. Have you ever had a blackout(s)/altered level of consciousness? Yes ☐ No ☐

If yes, please give the date DD MM YY

7. Have you ever had any form of seizure(s)/epileptic attack(s)? Yes ☐ No ☐

If yes, please indicate the diagnosis (tick the relevant box). ***If no, go to Q11***

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

First ever seizure ☐ ***(Go to Q8)***

More than one seizure ever or epilepsy ☐ ***(Go to Q9)***

8. First ever seizure:

Please provide the date of the seizure DD ☐☐ MM ☐☐ YY ☐☐

9. More than one seizure ever or epilepsy:

(a) Have you ever had 2 or more seizures within a 5 year period? Yes ☐ No ☐

Please provide the following dates:

		DD	MM	YY
(b)	First awake seizure	☐☐	☐☐	☐☐
	Last 2 awake seizures	☐☐	☐☐	☐☐
		☐☐	☐☐	☐☐
(c)	First sleep seizure	☐☐	☐☐	☐☐
	Last 2 sleep seizures	☐☐	☐☐	☐☐
		☐☐	☐☐	☐☐

(d) If you have had both awake and sleep attacks, please give the date of the first sleep attack after the last awake attack. DD ☐☐ MM ☐☐ YY ☐☐

(e) Have your seizures ever affected your level of consciousness? Yes ☐ No ☐
If yes, go to Q9f. If no, go to Q11

(f) Would your seizures ever have caused difficulty controlling a vehicle? Yes ☐ No ☐
If yes, please give full description of the attack

_____

_____

_____

_____

10. If you have been advised by a doctor that your seizure was provoked, please provide details of the circumstances of the seizure and provoking factor.

_____

_____

_____

_____

Declaration

This declaration needs to be signed if you have had a diagnosis of epilepsy or had more than 1 seizure

I agree to:

- ❖ follow the advice of my doctor(s) about the treatment for this condition.
- ❖ attend where necessary, appointment to monitor my condition.
- ❖ inform DVLA should I experience any further attacks.

Signed: _____ Date: _____

11. Has your condition caused problems with your eyesight? Yes ☐ No ☐

If yes, please give details: _____

12. Do you have double vision (diplopia)? Yes ☐ No ☐

If yes, please answer the following questions. ***If no, go to Q13***

(a) Do you ensure your double vision is suppressed or controlled? Yes ☐ No ☐

(b) If yes, how do you ensure your double vision is suppressed or controlled while driving?

Patch ☐ Prism ☐ Glasses/lenses ☐ Other ☐

If "Other", please give details: _____

13. Do you need help from another person with your day to day living? Yes ☐ No ☐

If yes, please give details of how they help you

_____

_____

14 Can you safely control a vehicle? Yes ☐ No ☐

15. Do you need special controls or automatic transmission to safely control a vehicle? Yes ☐ No ☐

If you answered No you DO NOT need to answer Q15a and 15b

(a) Have you told us before that you need special controls or automatic transmission? ***If yes, please answer Q14b*** Yes ☐ No ☐

(b) Since your last licence was issued, have you had any additional controls fitted to your vehicle? Yes ☐ No ☐

If you have any relevant hospital notes about your medical condition, please send copies with this form.

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. 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.