Driver & Vehicle Licensing Agency

B1V

B1V
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:

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Medical questionnaire – neurological – vocational

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

1. Please tick the appropriate box (es) if you have ever suffered from any of the following:

			DD	MM	YY
a)	Brain haemorrhage (including subarachnoid, aneurysm & AVM) Please give details _____	☐			
b)	Severe head injury involving in-patient treatment Please give details _____	☐			
c)	Any other condition If ticked, please give details _____	☐			
d)	Please give date of any brain surgery	Not applicable ☐			

2. Who did you last see for the treatment of this condition **GP** ☐ **Consultant** ☐

a) 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						

3. Have you ever had an operation to have an insertion or upper end revision of a VP shunt or external ventricular drain? Yes ☐ No ☐

	DD	MM	YY
If yes, please give the date			

4. Have you ever had a blackout/altered level of consciousness? Yes ☐ No ☐

	DD	MM	YY
If **yes**, please give the date			

5. Have you ever had any form of seizures or epileptic attacks? Yes ☐ No ☐

If no, please go to Q8.

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 ☐
If you tick this go to Q6

More than one seizure ever or epilepsy ☐
If you tick this go to Q7

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6. First ever seizure

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

Please give details: _____

_____

_____

7. More than one seizure ever or epilepsy

a) Have you ever had two or more seizures in a 5 year period? Yes ☐ No ☐

Please provide the following dates

		AWAKE DD	AWAKE MM	AWAKE YY			SLEEP DD	SLEEP MM	SLEEP YY
b)	First awake seizure				c)	First sleep seizure			
d)	Last 2 awake seizures				e)	Last 2 sleep seizures			

f) If you have had both awake and sleep attacks, please give the date of the first sleep attack after the last awake attack. | | | |

g) Are you currently on anti-epileptic medication? Yes ☐ No ☐

	DD	MM	YY
h) If no longer treated, please give the date the treatment stopped			

i) Have your seizures ever affected your level of consciousness? Yes ☐ No ☐

If yes, please go to Q7j, if no, go to Q7k

j) Would your seizures ever caused difficulty controlling a vehicle? Yes ☐ No ☐

If no, to Q7i or Q7j, please give a full description of the attack.

_____

_____

k) Was your last seizure a result of advice from your doctor to either stop, reduce or change your epilepsy medication? Yes ☐ No ☐

If you have answered no to Q7k go to Q7l

	DD	MM	YY
(i) Please give the date you started to reduce/change your medication.			

(ii) Has the previously effective medication been restarted? Yes ☐ No ☐

	DD	MM	YY
(iii) Please give the date the previously effective medication was restarted.			
(iv) Please give the date of your last seizure prior to the medication withdrawal or reduction of medication seizure			

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

_____

_____

_____

Please complete the declaration below if appropriate

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 treatment for this condition
- attend where necessary, appointments to monitor my condition
- inform the DVLA should I experience any further attacks

Signed: _____ Date: _____

8. Please give the name of any medication that you take/have taken No medication taken ☐

NAME OF MEDICATION	START DATE DD	START DATE MM	START DATE YY	END DATE DD	END DATE MM	END DATE YY

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

9. 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 _____

_____

_____

10. Do you have double vision (diplopia)? Yes ☐ No ☐
If yes, please answer the following questions.
If no, please go to Q11

a) Is your double vision 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 _____

_____

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

If yes, please name the condition and how it affects you _____

_____

12. Do you need to drive a vehicle fitted with special controls or automatic transmission for Group 1 vehicles? ***(Cars and Motorcycles)*** or Group 2 vehicles ***(Buses and Lorries)?*** Yes ☐ No ☐

If yes, please indicate Group 1 ☐ Group 2 ☐

a) Have you told us before that you need special controls or automatic transmission? 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.