Driver & Vehicle Licensing Agency

FEP1

FEP1
Rev Aug 25

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

FEP1

Medical questionnaire - Epilepsy/Seizures/Blackouts

Epileptic seizures can be experienced in many ways and could involve fits, convulsions, or seizures. Epilepsy may also occur only as unusual sensations such as smells, tastes, or feelings (known as an aura), absences or blank spells, limb jerking or twitching. Epileptic episodes may occur whilst asleep or when awake.

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

Cause of the episode(s) leading to loss or altered level of consciousness

1 Do you know what the cause or diagnosis of the episode(s) was/were? Yes ☐ **Go to Q2** No ☐

a) If no, please tell us the date(s) of episode(s):

First episode			Last episode		
DD	**MM**	**YY**	**DD**	**MM**	**YY**

Go to Applicant's declaration

Single seizure (1 seizure)

2 Have you only had one seizure? Yes ☐ No ☐ **Go to Q10**

a) If yes, please tell us the date of seizure:

DD	**MM**	**YY**

3 Was your seizure caused by eclampsia? (related to pregnancy) Yes ☐ No ☐

4 Was your seizure caused by electroconvulsive therapy? Yes ☐ No ☐

5 Was your seizure caused by repetitive transcranial magnetic stimulation? Yes ☐ No ☐

6 Did your seizure occur at the very moment of impact of a head injury? Yes ☐ No ☐

7 Did your seizure occur **less** than 7 days after a head injury? Yes ☐ No ☐

8 Did your seizure occur **more** than 7 days after a head injury? Yes ☐ No ☐

9 Please tell us the date of the head injury (if applicable):

DD	**MM**	**YY**

Go to Applicant's declaration

Multiple seizures (more than 1 seizure)

If you have multiple seizures within a 24-hour period, this is classed as a single event under the epilepsy and seizure regulations for driver licensing, you should fill in 'Single seizure (1 seizure)' only.

10 Have you had more than one seizure? Yes ☐ No ☐ **Go to Q20**

11 Have you been told by your healthcare professional that all your seizures were provoked? Yes ☐ No ☐

Provoked means that your seizures were caused by an identifiable trigger, for example infection, substance use, metabolic imbalances such as blood sugar, or seizures which occur in the first 7 days after a head injury or stroke.

12 Have you ever had 2 or more seizures in a 5-year period? Yes ☐ No ☐

13 Please tell us the dates of seizures:

Awake seizures	DD	MM	YY	**Asleep seizures**	DD	MM	YY
First awake seizure				First asleep seizure			
Last 2 awake seizures				Last 2 asleep seizures			

14 If you have had both awake and asleep seizures, please tell us the date of the first asleep seizure, after the last awake seizure:

DD	MM	YY

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

16 Would your seizures have ever caused difficulty controlling a vehicle? Yes ☐ No ☐

17 Was your last seizure caused by either stopping, reducing or changing your epilepsy medication following advice from your doctor? Yes ☐ No ☐ **Go to Applicant's declaration**

a) If **'Yes'**, please tell us the date your medication was stopped, reduced or changed:

DD	MM	YY

18 Has the previously effective medication been restarted? Yes ☐ No ☐ **Go to Applicant's declaration**

Multiple seizures (more than 1 seizure) continued

a) If **'Yes',** please tell us the date this medication was restarted:

DD	MM	YY

19 Please tell us the date of your last seizure before the medication was stopped, reduced, or changed:

DD	MM	YY

Go to Applicant's declaration

Dissociative seizures (also known as "non-epileptic attack disorder" or "functional seizures")

This means you may experience episodes of uncontrolled movements, sensations, behaviours or seizures like epilepsy that you have no control over. These are not due to epilepsy or abnormal activity in the brain. Dissociative seizures are often associated with underlying mental health conditions, such as trauma, stress or emotional distress.

20 Have you had dissociative/functional seizures? (including non-epileptic attack disorder). Yes ☐ No ☐ **Go to Q23**

a) If **'Yes'**, please tell us the date of the last seizure:

DD	MM	YY

21 Have any of the events happened whilst driving? Yes ☐ No ☐

22 Was this related to a mental health condition? Yes ☐ No ☐

Go to Applicant's declaration

Blackout(s), loss or altered level(s) of consciousness

23 Have you had blackout(s), or altered level(s) of consciousness? Yes ☐ No ☐ **Go to Applicant's declaration**

a) If **'Yes'**, please tell us the date(s) of the blackout(s) or altered level(s) of consciousness:

First episode

DD	MM	YY

Last episode

DD	MM	YY

24 Has the cause of the blackout(s) / altered level(s) of consciousness been identified by your healthcare professional? Yes ☐ No ☐

25 Have you had an episode(s) of cough syncope? Yes ☐ No ☐

Blackout(s), loss or altered level(s) of consciousness continued

a) If **'Yes'**, please tell us the date(s) of cough syncope.

First episode			Last episode		
DD	**MM**	**YY**	**DD**	**MM**	**YY**

26 Have you had a pacemaker, or a CRT-P implanted? Yes ☐ No ☐ **Go to Q28**

a) If **'Yes'**, please tell us the date the device was implanted:

DD	**MM**	**YY**

27 Was the device implanted because of blackout(s) or altered level(s) of consciousness? Yes ☐ No ☐ **Go to Q28**

a) If '**Yes'**, have the blackout(s) or altered level(s) of consciousness now been controlled since the device was implanted? Yes ☐ No ☐ **Go to Q28**

28 Have you had a defibrillator or an ICD/CRT-D implanted? Yes ☐ No ☐ **Go to Applicant's declaration**

a) If **'Yes'**, please tell us the date the device was implanted:

DD	**MM**	**YY**

29 Was the device implanted because of blackout(s) or altered level(s) of consciousness? Yes ☐ No ☐ **Go to Q30**

a) If **'Yes'**, have the blackout(s) or altered level(s) of consciousness now been controlled since the device was implanted? Yes ☐ No ☐

30 Has the device delivered shock therapy and/or ATP (anti tachycardia pacing) associated with incapacity? (with you being unable to function as usual due to the shock/ATP or arrhythmia) Yes ☐ No ☐ **Go to Q32**

a) If **'Yes'**, please tell us the date the device delivered a shock/ATP therapy.

DD	**MM**	**YY**

31 Was the shock / ATP due to atrial fibrillation (arrhythmia) or a programming issue? Yes ☐ No ☐

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

As a driver with an implantable device such as pacemaker, CRT-P, defibrillator or ICD/CRT-D, I agree to:

- undergo regular check-ups for my implantable device as advised by my healthcare professional
- follow the advice of my healthcare professional for the treatment of my heart condition.
- notify DVLA if I suffer any sudden attacks of disabling giddiness, fainting or blackout(s)
- FOR DEFIBRILLATOR (ICD/CRT-D), notify DVLA if my implanted device delivers "shock" therapy or ATP (anti-tachycardia pacing) with dizziness/loss of consciousness (unless this has occurred during clinical testing).

Put an **'X'** in the box if you agree with the following statement:

"I have an implantable device and I agree to comply with the above conditions if I am issued with a car or motorcycle (group 1) driving licence". ☐

Please read and sign the applicant's declaration

Applicant's Declaration

Please read the following information carefully, sign and date the declaration agreeing to the statements below. You must not alter it in any way.

I understand that it is a criminal offence if I make a false declaration to obtain a driving licence and can lead to prosecution.

I agree to the following statements:

- I will follow the advice of my healthcare professional(s) about treatment for this/these health condition(s)
- I will comply with follow up arrangements to monitor my health condition(s)
- I will inform DVLA should I become aware my health condition gets worse, or I experience any further seizures and/or blackout(s)/altered level of consciousness, sudden attacks of disabling giddiness or fainting

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.

Declaration: (please sign and date if you agree with the statements above)

Signature _____ Today's Date

DD	MM	YY

Driver & Vehicle Licensing Agency

Rev July 22

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 the 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 via electronic channels (email) **Yes** ☐ **No** ☐

If you would like to be contacted about your application by email or text message (SMS) by a healthcare professional acting on behalf of the DVLA please tick the appropriate boxes below.
If no boxes are ticked, you will be contacted by post.

Email ☐ **SMS (Text)** ☐

If you would like to be contacted about your application by email or text message (SMS), please tick the appropriate boxes. If no boxes are ticked, DVLA will continue to contact you by post.

Email ☐ **SMS (Text)** ☐

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.

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