Driver & Vehicle Licensing Agency

PAH1V

PAH1V
Rev June 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:

Speciality: Department:

Hospital name:

Address:

Town:

Postcode:

Contact number:

Email:

Date last seen for this condition:

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Pulmonary Arterial Hypertension self declaration

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

1 Please confirm you have a diagnosis:

1a PAH (Pulmonary Arterial Hypertension) Yes ☐ No ☐

1b Chronic Thromboembolic Pulmonary Hypertension Yes ☐ No ☐

2 Have you ever attended or are you due to be seen at one of the following hospitals?

Yes ☐ No ☐ If No go to Q4

***Note**: If you are attending a local clinic/hospital but have previously attended/due to attend one of the hospitals below please put an X in the relevant box.*

Freeman Hospital, Newcastle	☐	Golden Jubilee Hospital, Glasgow	☐
Great Ormond St Hospital, London	☐	Hammersmith Hospital, London	☐
Papworth Hospital, Cambridgeshire	☐	Royal Brompton Hospital, London	☐
Royal Free Hospital, London	☐	Royal Hallamshire Hospital, Sheffield	☐

3 Please tell us the name of the consultant you have seen (or are due to see) at the above hospital?

Consultant's name: _____

3a Please tell us date you last attended (or are due to attend) the above hospital?

DD	MM	YY

4 If you have not attended one of the hospitals above, please confirm:
I have never attended/not due to attend any of the hospitals listed in Q2 ☐

5 Have you had any blackout episodes(s)? Yes ☐ No ☐ Go to Q8
This would include fainting/collapse or feeling you may faint/collapse

Please confirm

5a I have had **only one** episode ☐

5b I have had **two or more** episodes ☐

5c Please give the date of the most recent episode

DD	MM	YY

6 Has a healthcare professional given a cause/diagnosis for the blackout episode(s)?

6a **Yes** – caused by Pulmonary Arterial Hypertension ☐
6b **Yes** – another cause Not Pulmonary Hypertension ☐
6c **No** - no cause has been found ☐

7 Have you received treatment to prevent further blackout episode(s)?

Yes ☐ No ☐

7a If **'Yes'** please give details of the treatment.

_____

_____

_____

8 Have you been advised by a healthcare professional that you are unfit to drive due to Pulmonary Arterial Hypertension?

Yes ☐ No ☐

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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)** ☐

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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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gov.uk/dvla