Driver & Vehicle Licensing Agency

BT1V

BT1V
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:

Brain tumour self declaration

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

Section A – About your health condition

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

If '**No'** go to **Q5**

a) If **'Yes**', put an '**X**' in all boxes that apply.

- Meningioma ☐
- Glioblastoma ☐
- Pituitary tumour ☐
- Glioma ☐
- Metastatic disease ☐
- Other ☐

2 When was your brain tumour diagnosed? **Date** ☐☐☐

Section B – About your medical treatment

3 How has the tumour been managed? Put an '**X**' in all boxes that apply.
Please tell us the start date of your initial treatment and the end date of your most recent treatment. If your treatment is ongoing, please tell us the start date only.

Observation	☐		
Biopsy	☐	**Start** ☐☐☐	**End date** ☐☐☐
Surgery	☐	**Start** ☐☐☐	**End date** ☐☐☐
Radiotherapy, SRS, Gamma knife, Proton beam therapy	☐	**Start** ☐☐☐	**End date** ☐☐☐
Chemotherapy	☐	**Start** ☐☐☐	**End date** ☐☐☐
Immunotherapy or targeted molecular therapy	☐	**Start** ☐☐☐	**End date** ☐☐☐

4 Who was the last healthcare professional you saw for your brain tumour? (Any phone, video or face to face consultation).

GP ☐ Consultant ☐ Nurse specialist at hospital clinic ☐

a) Please tell us the date of your last contact with that healthcare professional

DD MM YY ☐☐☐

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Section B continued

5 Have you had a device fitted that relieves pressure on the brain due to excess fluid? (For example, a VP shunt). **Yes** ☐ **No** ☐ If '**No**' go to **Q6**

a) If '**Yes**', please tell us the date. **Date** ☐☐☐

Section C – Blackout(s) and seizure(s)

6 Have you ever had a blackout(s) or altered level of consciousness? **Yes** ☐ **No** ☐ If '**No**', go to **Q16**

a) If '**Yes**', please tell us the date(s) of the first and last episode(s)

1st episode ☐☐☐ **Last episode** ☐☐☐

7 Have you ever had any form of seizure(s) or epileptic seizure(s)? **Yes** ☐ **No** ☐ If '**No**', go to **Q16**

8 Have you only ever had one seizure? **Yes** ☐ **No** ☐ If '**No**', go to **Q9**

a) If '**Yes**', please tell us the date of the seizure **Date** ☐☐☐

9 Have you ever had 2 or more seizure(s) in a 5-year period? **Yes** ☐ **No** ☐

10 Please tell us the dates of seizure(s):

First awake seizure	☐☐☐	First asleep seizure	☐☐☐
Last 2 awake seizures	☐☐☐	Last 2 asleep seizures	☐☐☐
	☐☐☐		☐☐☐

11 If you have had both awake and asleep seizures, please tell us the date of the 1st sleep seizure, after the last awake seizure. **Date** ☐☐☐

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

13 Have your seizures ever caused difficulty controlling a vehicle? **Yes** ☐ **No** ☐ If '**No**', go to **Q14**

a) If '**Yes**', please tell us a full description of the seizure(s)

Section C continued

14 Are you currently on anti-seizure medication? **Yes** ☐ **No** ☐

If '**Yes**', go to **Q15**

a) If no longer treated, please tell us the date the treatment ended **Date** ☐☐ ☐☐ ☐☐

15 If your healthcare professional has told you that something caused your seizure, please tell us what happened and what the cause was _____

_____

_____

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 agree to the following statements:

- To follow the advice of my healthcare professional about the treatment for this condition.
- To 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 / 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** ☐☐

Section D – About your vision/eyesight

16 Has your brain tumour caused problems with your vision/ eyesight? **Yes** ☐ **No** ☐

If '**No**', please go to **Q18**

a) If '**Yes**', please tell us the details: _____

_____

_____

17 Do you have double vision (diplopia)? **Yes** ☐ **No** ☐

If '**No**', please go to **Q18**

a) If '**Yes**', is it controlled? **Yes** ☐ **No** ☐

b) If '**No to Q17a**', has your vision been the same for 6 months or more? **Yes** ☐ **No** ☐

Section D continued

Double Vision Declaration

It can take 3 months or more for you to adapt to driving wearing a patch, prism, frosted glasses or lenses because:

- your ability to judge distances may be affected
- you may not be aware of objects each side of you

You should not drive until you have been advised by your healthcare professional or optician/optometrist that you have fully adapted to wearing a patch, prism, frosted glasses or lenses and/ or other treatments.

Please put an '**X'** in the box to confirm that you have read and understood the information above. ☐

Signature: _____ Today's date DD ☐☐ MM ☐☐ YY ☐☐

Section E – Memory and concentration

18 Have you or your family noticed you have cognitive problems which may affect driving? (For example, difficulties with remembering things, concentrating, making decisions and solving problems) **Yes** ☐ **No** ☐

Section F - Special Controls

19 Can you safely control a vehicle? **Yes** ☐ **No** ☐

20 As a result of your health condition, do you have any problems with your limbs that affect your ability to control your vehicle safely? ***If 'No', do not complete the rest of this form*** **Yes** ☐ **No** ☐

a) If '**Yes'**, as a result of your health condition, do you have to drive a vehicle with special controls? If **'No'** go to **Q21** **Yes** ☐ **No** ☐

Section F - Special controls continued

20b If '**Yes**', please tell us of any modifications that you need to drive a:

	Car	Bus or Lorry
• transmission (10)	☐	☐
• clutch (15)	☐	☐
• braking system (20)	☐	☐
• accelerator system (25)	☐	☐
• pedal adaptions and safeguards (31)	☐	☐
• combined service brake and accelerator systems (32)	☐	☐
• combined service brake, accelerator and steering systems (33)	☐	☐
• control layouts (35)	☐	☐
• steering (40)	☐	☐
• rear view mirror (42)	☐	☐
• driver seat (43)	☐	☐

If '**Yes',** please tell us of any modifications that you need to drive a:

Motorcycle, Moped or Tricycle	
• single operated brake (44.01)	☐
• adapted front wheel brake (44.02)	☐
• adapted rear wheel brake (44.03)	☐
• adjusted accelerator (44.04)	☐
• adjusted manual transmission and clutch (44.05)	☐
• adjusted rear view mirror (44.06)	☐
• adjusted commands (for example lights, indicators) (44.07)	☐
• seat height (allows the driver to have 2 feet on the surface at once and balance the wheel when stopping/standing) (44.08)	☐
• adapted footrest (44.11)	☐
• adapted hand grip (44.12)	☐
• motorcycle with sidecar only (45)	☐

21 As a result of your health condition, have you been told that you can only drive a vehicle with automatic gears?
Do not mark '**Yes**' if you drive a vehicle with automatic gears by choice.

Yes ☐ **No** ☐

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

Driver & Vehicle Licensing Agency

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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)** ☐

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.