Driver & Vehicle Licensing Agency

# STR1

**STR1**
*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:

# STR1

**Stroke – self declaration**

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

**Reminder: you must not drive for at least 1 month from the date of your stroke / transient ischaemic attack (TIA).**

## Your condition

1 Please tell us your health condition. Put an **'X'** in the box that applies.

| | |
|---|---|
| Stroke | ☐ |
| TIA | ☐ |
| Retinal artery occlusion | ☐ |
| Other stroke related condition including cerebral venous thrombosis and amaurosis fugax | ☐ |

1a Please tell us the date of the most recent episode:

| DD | MM | YY |
|---|---|---|
| | | |

## Symptoms and effects

2 One month after the episode, are you still experiencing any lasting effects that haven't completely resolved, even if you have undergone treatment and therapy? Yes ☐ No ☐ **If 'No' go to Q10**

If **'Yes'**, please indicate below what ongoing effects you have.

3 Do you have weakness in your arms, legs or body, for example experiencing changes in sensation, difficulty with co-ordination or balance? Yes ☐ No ☐

4 Have you experienced problems with your memory or thinking for example, making decisions, getting lost or disorientated, thinking clearly or concentrating? Yes ☐ No ☐

5 Has the stroke caused any problems with your eyesight? **Do not include long or short sightedness** Yes ☐ No ☐ **If 'No' go to Q9**

6 Do you have a problem with your field of vision? (Your field of vision is the area you can see when looking straight ahead). Yes ☐ No ☐

7 Do you experience visual inattention? (As diagnosed by your healthcare professional, not visual field loss). Yes ☐ No ☐

8 Do you have double vision (diplopia)? Yes ☐ No ☐
**If 'No' go to Q9**

8a If '**Yes'**, is it controlled? Yes ☐ No ☐

8b If **'No'**, has your double vision been the same for 6 months or more? Yes ☐ No ☐

**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.

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

Signature: _____ Date: DD ☐☐ MM ☐☐ YY ☐☐

9 Do you have any other ongoing symptoms from your stroke that would affect your ability to drive safely? Yes ☐ No ☐

If 'Yes', please tell us the details: _____

_____

10 Have you had an on-road driving assessment since your last stroke? Yes ☐ No ☐

If **'Yes'**, and you have a copy, please enclose it with this form.

**Seizure(s) / Epilepsy**

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

11 Have you ever had any form of seizure(s) / epileptic seizures? Yes ☐ No ☐
**If 'No' go to Q15**

12 First ever seizure – please tell us the date of the seizure: DD ☐☐ MM ☐☐ YY ☐☐

**If you have had more than 1 seizure ever, or been diagnosed with epilepsy, please complete questions 13 and 14.**

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

Please tell us the dates (if applicable) of the:

**Awake seizures**

13a First awake seizure DD MM YY

13c Last 2 awake seizures DD MM YY

DD MM YY

**Asleep seizures**

13b First asleep seizure DD MM YY

13d Last 2 asleep seizures DD MM YY

DD MM YY

13e If you have had both awake and sleep seizures, please tell us the date of the first sleep seizure after the last awake seizure. DD MM YY

13f Have your seizures ever affected your level of consciousness? Yes ☐ No ☐

13g Would your seizures have ever caused difficulty controlling a vehicle? Yes ☐ No ☐

14 If you have been advised by your healthcare professional that your seizure was a provoked or an acute symptomatic seizure, please tell us the full details of the circumstances of the seizure and the provoking factor: _____

_____

**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 condition(s)
- I will comply with the 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 blackouts / 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.

Signature: _____ Date: DD MM YY

**Special controls**

15 As a result of your health condition, do you have any problems with your limbs that affect your ability to control your vehicle safely? Yes ☐ No ☐ **If 'No' go to Q17**

15a As a result of your health condition, do you have to drive a vehicle with special controls? Yes ☐ No ☐ **If 'No' go to Q16**

15b 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 (light, indicators etc.) (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) ☐

16 As a result of your health condition, have you been told 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 ☐

**Healthcare professional**

17 Who was the last healthcare professional you saw for your stroke (any phone, video, or face to face consultation)?

GP ☐ Consultant ☐ Nurse specialist at hospital clinic ☐

17a Please tell us the date of your last contact with that healthcare professional:

| 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