Confidential medical information

DIAB1 ONLINE
(Rev Apr 12)

PART A: ABOUT YOU

Please answer the questions on this form in **BLOCK CAPITAL** letters using **BLACK INK**

Title: (Mr, Mrs, Miss, Other?) Surname: Date of Birth:

First Name(s): Driver No:

Address:

Postcode

Telephone Number(s):
Home
Mobile

Email

PART B: ABOUT YOUR GP AND YOUR CONSULTANT

GP's Name and Address

Dr:

Postcode:

Consultants Name and Address

Title:

Postcode:

TEL No: *(Including dialling code)*

TEL No: *(Including dialling code)*

Date last seen by GP (For this condition)

Date last seen by Consultant (For this condition)

If you have more than one consultant, please give their name and address on a separate sheet.

GP email address *(if known)*

Consultants email address *(if known)*

Hospital number *(if known)*

PART C: Please give details of other clinics you are attending below

Name of clinic	Reason for attendance	Date last seen

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This form is to be filled in by you. If you need help to fill it in you are advised to speak to your GP or for a guide on how to fill in this form visit www.gov.uk/diabetes-driving

PART D

Section 1: About Your Diabetes

1a. Please tell us how your diabetes is treated?

- ☐ Insulin injection
- ☐ Insulin Pump
- ☐ Other non-insulin injectable treatment
- ☐ Tablets

1b. Approximate date insulin treatment started: ☐☐☐ Date

DECLARATION: **For Insulin treated only** – I have insulin treated diabetes and I understand the need to test my blood glucose/sugar at times relevant to driving (within 30 minutes before the first journey and every two hours while driving).

Signature:

Date:

2a. Who do you regularly see for your diabetes care?
This is for management of your blood sugar/glucose.

- ☐ Consultant
- ☐ GP
- ☐ Nurse Specialist at hospital clinic
- ☐ GP Nurse

2b. How many times, in the last 12 months, have you seen the person in 2a for your diabetes care?
Do not include attendance at eye or chiropody clinics.

- ☐ 0 times
- ☐ 1-4 times
- ☐ 5 Plus

Date of last appointment: ☐☐☐ Date

3a. Are you aware of the symptoms of hypoglycaemia?
e.g. sweating, shakiness, hungry, palpitations, tingling lips

- ☐ Yes
- ☐ No

3b. Have you had an episode of hypoglycaemia?
IF NO, CONTINUE TO SECTION 2

- ☐ Yes
- ☐ No

3c. Have you had more than one episode of **severe** hypoglycaemia (requiring assistance from another person) in the last 12 months? ***Do not count episodes where you were given help but could have helped yourself.***

- ☐ Yes
- ☐ No

3d. If **YES** to 3c, provide dates of two most recent events:

- ☐☐☐ Date
- ☐☐☐ Date

3e. Do you get warning symptoms of hypoglycaemia?

- ☐ Yes
- ☐ No

3f. If **YES** to 3e, are you always aware?

- ☐ Yes
- ☐ No

NAME	DOB	REF

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Section 2: Special Controls

1.	Do you need to drive a vehicle with special controls or automatic transmission? ***If you answered NO to question 1 go straight to section 3.***	☐ Yes	☐ No
2.	Have you told us before that you need special controls or automatic transmission? ***If you answered YES to question 2 please answer question question 3, if you answered no go straight to question 4***	☐ Yes	☐ No
3.	Since your last licence was issued have you had any additional controls fitted to your vehicle?	☐ Yes	☐ No
4.	Due to a change in driving licence rules, entitlement to drive tricycles which used to be part of category B will now be shown separately on your licence as category A79 and you will need to specify which controls you would require to drive such a vehicle. Do you wish to have entitlement to drive a tricycle on your licence?	☐ Yes	☐ No

Section 3: Your Eyesight

1a.	Can you read a number plate from 20 metres in good light with glasses or corrective lenses if worn?	☐ Yes	☐ No
1b.	Has your doctor or optician advised you that your eyesight does not currently meet the minimum standard for driving? ***A visual acuity of 6/12 (0.5) or better must be achieved with the aid of glasses or contact lenses if necessary.***	☐ Yes	☐ No
2.	Do you need to wear glasses or contact lenses when you are driving?	☐ Yes	☐ No
3.	Do you have total loss of sight in one eye?	☐ Yes	☐ No
4.	Have you had laser treatment or injections into both eyes (or remaining eye) for diabetic eye disease or another eye condition? ***Do NOT include corrective surgery for short sightedness.***	☐ Yes	☐ No
	If **YES**, please supply the date of your laser treatment:	☐☐☐ Date	
5.	Do you have cataracts or any corneal dystrophies (e.g. Fuchs) in both eyes or remaining eye?	☐ Yes	☐ No

NAME	DOB	REF

CONSENT

Please read the following information carefully and then sign the statement below. This section MUST be completed and must NOT be altered in any way.

Important information about Consent

You will see that we have asked you for your consent for the release of medical reports from your doctors as we may require further information. In addition, as a part of the investigation into your fitness to drive, DVLA may require you to undergo a medical examination or some form of practical assessment.

In these circumstances, those personnel involved will require your background medical details to undertake an appropriate and adequate assessment. Such personnel might include Doctors, Orthoptists at eye clinics or Paramedical Staff at a Driving Assessment centre. Only information relevant to the assessment of your fitness to drive will be released.

In addition, where the circumstances of your case appear exceptional, the relevant medical information would need to be considered by one or more of the Secretary of State's Honorary Medical Advisory Panels. The membership of these Panels conforms strictly to the principle of confidentiality.

All data held by DVLA is used for internal evaluation of the quality of our services.

Consent and Declaration

I authorise my Doctor(s) and Specialist(s) to release reports/medical information about my condition relevant to my fitness to drive, to the Secretary of State's medical adviser.

I authorise the Secretary of State to disclose such relevant medical information as may be necessary to the investigation of my fitness to drive, to Doctors, Paramedical staff and 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 :

Inform my Doctor(s) of the outcome of my case	**YES**	☐	**NO**	☐
Release medical information, discovered during the investigation into my fitness to drive, to Doctor(s)	**YES**	☐	**NO**	☐

Electronic Release of Information

DVLA is able to request and receive medical information by fax and email from you, your doctor(s) or any relevant personnel associated with your medical enquiry

All information held by DVLA is treated with strict confidentiality. E-mails with personal information will be sent by DVLA to medical professionals only where a secure network is available. The security of the electronic transmission of information over the Internet cannot be guaranteed and DVLA cannot accept responsibility for e-mails or faxes sent by others, until they have been received by us. If we are unable to communicate in this way, conventional postage methods will be used instead. You must confirm in writing if you wish to cancel the agreement to communicate electronically.

Do you agree to DVLA communicating with you by fax and / or email	**YES**	☐	**NO**	☐
Do you agree to DVLA communicating with your Doctors, Orthoptists or relevant personnel by fax and / or e-mail?	**YES**	☐	**NO**	☐

NAME	DOB	REF

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 fax

0845 850 0095

Find out about DVLA's online services

Go to: www.direct.gov.uk/onlinemotoringservices