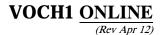


NAME

Confidential medical information



PART A: ABOUT YOU

1 / 1 / 1 / 1 / 1 / 1																		
]	Please	answ	er the	questio	ons on	this fo	rm in	BLC	CK CAF	PITAI	L letters	susing	BLAC	CK INI	ζ.		
Title:		Sur	name	:							Da	ate of I	Birth:					
(Mr, Mrs, N	Miss, O	ther?)									_							
First Name	e(s):								Dri	ver No:								
Address: Telephone Number								er(s):										
												Home						
							Mobile						e					
	Postc	ode										Email						
PART B:	ABOU	Т Y(OUR	GP A	ND Y	OUR	CON	SUL	TAN	T								
Dr:		GP's	s Nam	e and	Addre	ess				Title:		Consu	ltants	Name	and A	ddress		
	_			Γ		T	1	ı				1	1	1	1	1		1
Postco	de:									Postco	de:							
TEL No:	(Inclu	ding o	diallinį	g code	·)				T1	EL No:	(Inc	cluding	diallinį	g code)			
Date last se	en by C								 Date	e last see	n by (Consult	ant					
(For this co		<u>L</u>								this cond								
If	you h	ave n	nore 1	than (one co	nsult	ant, p	lease	give	their na	ame a	and ad	ldress	on a	separa	te shee	et.	
GP email a	address	(if kı	nown)		_													
Consultant	s email	addı	ress (1	if knov	vn)													
Hospital m	umber	(if kn	own)		_													
PART C:	Please	give	detai	ls of o	other	clinic	s you	are a	tten	ding belo)W							
	Name	of cl	<u>inic</u>				<u> </u>	Reaso	n fo	r attenda	ance				<u>D</u> :	ate see	1	

DOB

REF

MEDICAL IN CONFIDENCE



		YES	NO		DATE
)	Angina			Last attack	
))	Heart Attack (Myocardial Infarction) or Acute Coronary Syndrome				
:)	Angioplasty/Stent			Date of most recent procedure	
l)	Heart By-Pass Surgery(CABG)				
:)	Abnormal Heart Rhythm (Arrhythmia)			Date of most recent episode	
)	Pacemaker			Date Implanted	
g)	Defibrillator			Date Implanted	
1)	Peripheral Arterial Vascular Disease			Date last seen	
)	Aortic Aneurysm			Date last seen	
)	Heart Failure			Date last seen	
x)	Has a special pacemaker been implanted to improve your heart failure?			Date Implanted	
)	TIA/Stroke			Date of onset	
n)	Any other heart condition? - Please give details	S			

MEDICAL IN CONFIDENCE



2.		If required, would you be able to walk a brisk pace for 9 minutes?	at a Yes No
3	Ple	ase give details of your current medicatio	n:
	,	Name of Medication Dosage	Reason For Taking
4.	Ple	ase state your current height:	
	Ple	ase state your current weight:	
5.		ase indicate what type of cardiac invest : (tick ✓ relevant box)	tigations or procedures you have undergone or are waiting
;	a)	Exercise test or treadmill test	Yes No Date
	Dic	l you stop any medication 48 hours prid	or to the test? Yes No
	Do	yes state what medication was stopped you know how long you exercised for the nearest minute?	
1	b)	Myocardial Perfusion Scan/Stress Echo	Yes No Date
(c)	Coronary Angiography	
(d)	Echocardiogram	
(e)	Other If other please provide details below:	
5.		Do you have any other medical condit	tion? Yes No
		If YES, please give details	
NAN	ИE	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 YES NO investigation into my fitness to drive, to Doctor(s)								
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?								

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

