Confidential medical information

DIAB1V 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:

TEL No: *(Including dialling code)*

Consultants Name and Address

Title:

Postcode:

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

NOTE: Please read (and fill in if required) the enclosed VDIABDEC section of the questionnaire as it explains new changes to the diabetes regulations for anyone whose diabetes is controlled by certain tablets (sulphonylureas or glinides).

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

1. Please tell us how your diabetes is treated and the date the treatment started.

	Yes	MM	YY
a) Insulin?			
b) Other injectable treatment?			
c) Tablets? ***(Please see note * above)***			

If Yes, please give names of all tablets _____

2. Please tell us the type of diabetes you have

Type 1	Type 2	Other

If "Other", please specify: _____

	Yes	No
3. If treated with insulin, do you use a memory meter to check your blood sugar/glucose levels?		
a) If Yes, do you have 3 months of blood sugar/glucose readings stored on a memory meter?		
4. Have you had an episode of hypoglycaemia (low blood sugar) in the last 12 months?		

If Yes, please give details: _____

_____

	Yes	No
5. Have you had an episode of hypoglycaemia in the last 12 months which, required help from another person?		

If Yes, please give the dates of **ALL** episodes:

MM	YY	MM	YY	MM	YY

	Yes	No
6. a) Do you regularly check your blood sugar/glucose at least twice daily?		
b) Do you check your blood sugar/glucose at times relevant to driving?		
7. Do you keep fast acting carbohydrate in your vehicle when driving?		

NOTE: Please read (and fill in if required) the enclosed VDIABDEC section of this questionnaire. This is needed to ensure that you understand and meet the criteria if you take a sulphonylurea or glinide tablet to control your diabetes.

NAME	DOB	REF

		Yes	No
8.	When your blood sugar starts to fall and you are awake, do you have warning symptoms?		

If Yes, please give details of all episodes: _____

_____

		Yes	No
9.	Do other people recognise you are developing hypoglycaemia before you do?		
10. a)	Do you need to drive a vehicle fitted with special controls or automatic transmission for Group 1 vehicles? *(Car and Motorcycle)*		
b)	Do you need to drive a vehicle fitted with special controls or automatic transmission Group 2 vehicles? *(Bus, Lorry, Medium sized vehicle over 3500kG and Minibus)*		
11. a)	Can you read a number plate from 20 metres in good light with glasses or contact lenses if worn?		
b)	Has your doctor or optician advised you that your eyesight does not meet the minimum standard for driving? Visual acuity of 0.5 (6/12)		
c)	Do you need to wear glasses or corrective lenses when you drive?		
d)	Do you need to wear glasses or contact lenses to meet the legal eyesight standard for driving a bus or lorry?		
e)	Have you had your eyes tested in the last 6 months?		
12. a)	Do you have total loss of sight in one eye?		

		MM	YY
b)	If Yes, please supply the date of loss.		

		Yes	No	Left Eye	Right Eye
13. a)	Do you currently have cataracts?				
b)	Do you have diabetic maculopathy?				
c)	Have you had laser treatment for diabetic retinopathy?				

		MM	YY
d)	Please give the date you last had laser treatment.		

14. Please supply the date you last saw your GP or Consultant for your diabetes.

	Day	Month	Year		Day	Month	Year
GP:				Consultant:			

NAME	DOB	REF

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FOR THE OPTOMETRIST: IMPORTANT INFORMATION

Your patient has informed us that they currently have cataracts, maculopathy or any other macular disease and have had their eyes tested in the last 6 months. Please fill in this visual acuity certificate from their records. **You need not examine the patient**.

YOU WILL NOT BE PAID if you complete the form and your patient does not have any of the above conditions or the information you supply is more than 6 months old.

- Please provide the visual acuties using the 6 metre Snellen chart

Uncorrected acuities		**Corrected acuities** *(using the prescription currently worn for driving)*	
RIGHT EYE	**LEFT EYE**	**RIGHT EYE**	**LEFT EYE**

- Please give the best binocular acuity with corrective lenses if worn for driving. ☐

- Please give the date of the eye test

DD	**MM**	**YY**

- If glasses worn, is the distance spectacle prescription of either used of a corrective power greater than plus 8 (+8) dioptres?

Yes	**No**
☐	☐

- Please confirm (✓) the scale you have used to express the driver's visual acuitiess

Snellen ☐ **Snellen expressed as a decimal** ☐ **LogMAR** ☐

- Signature: _____

- Date: _____ Tel No: _____

- GMC, GOC, HPC No: _____ Renewal Date: _____

Opticians Stamp

On receipt a fee of £11.50 will be paid by DVLA
Please ensure that an invoice is enclosed with the completed form we are no longer able to make payment unless an invoice is provided. This applies to VAT and NON VAT requestors.

NAME	DOB	REF

IF YOUR DIABETES IS TREATED WITH INSULIN YOU MUST COMPLETE THE DECLARATION BELOW

Declaration: to be signed by all applicants who have **insulin** treated diabetes.

I declare that I will:

- comply with the directions of the doctors treating my diabetes
- report immediately to DVLA any significant change in my condition
- provide evidence on request that I regularly monitor my condition and in particular, undertake blood sugar/glucose monitoring, using a glucose meter with a memory function, at least twice daily and at times relevant to driving Group 2 vehicles.

Signature: _____ Date: _____

NAME	DOB	REF

A Guide for Group 2 (LGV/PCV) Drivers who have Diabetes treated with tablets in the Sulphonylurea or Glinide class

VDIABDEC
ONLINE

Sulphonylureas which include the following tablets:	**Glinides which include the following tablets:**
Chlorpropamide Glibenclamide also known as Euglucon Gliclazide also known as Diamicron or Diamicron MR Glimepiride also known as Amaryl Glipizide also known as Minodab and Glibenese Tolbutamide	Nateglinide also known as Starlix Repaglinide also known as Prandin

To meet the current Group 2 standards of medical fitness to drive an applicant or licence holder who has diabetes treated with a Sulphonylurea or Glinide (see above) **must** check their blood glucose (sugar) level at least twice daily and at times relevant to driving. Failure to do so will lead to the revocation or refusal of your Group 2 licence. If you are unsure what medication you are taking you may wish to discuss this with your GP.

You will also be required to keep a supply of fast acting carbohydrate such as glucose or sweets within easy reach in the vehicle.

Please only complete the Declaration below if your diabetes is treated with tablets in the Sulphonylurea or Glinide class (as shown above).

DECLARATION: I have read the above information and fully understand that to meet the Group 2 standards of medical fitness to drive I **will** check my blood glucose (sugar) level at least twice daily and at times relevant to driving. I will also keep a supply of fast acting carbohydrate such as glucose or sweets within easy reach in my vehicle.

Name (Sign): _____

Name (Print) _____

Date: _____

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