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:

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

DIAB1 ONLINE
Rev May 12

Version 3

Questionnaire to assess your medical fitness to drive

Please answer SECTION 1 AND SECTION 2 or your case will be delayed.
If you are unsure of the answers, we advise you to discuss this form with your Doctor.

PART D: SECTION 1: About your Diabetes

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

	Yes	No	Approximate Date treatment started MM	YY
a) INSULIN				

If **YES,** Please Sign and Date the Declaration below

DECLARATION: (must be completed if your diabetes is insulin- treated)

I have insulin-treated diabetes and I understand the need to test my blood glucose/sugar at times relevant to driving (before the first journey and every 2 hours while driving).

Signature _____ *Date* _____

	Yes	No
b) OTHER Injectable treatment (E.g. Exenetide, Liraglutide?)		
c) TABLETS		

2. Please tick in the box who you see regularly for your diabetes care (This is for management of your blood glucose/sugar).

GP >

GP PRACTICE NURSE >

CONSULTANTS CLINIC >

NURSE SPECIALIST AT HOSP CLINIC >

3. Please circle in a box below how many times in the last 12 months you have seen the person(s) you have declared at q2 for your diabetes care and the date of your last appointment. (Do not include attendance at eye clinic or chiropody clinics).

0	1-4	5 plus	MM	YY

NAME	DOB	REF

4. If you have **not** experienced an episode of hypoglycaemia are you aware of what the symptoms are? Yes ☐ No ☐
IF YOU ANSWER THIS QUESTION PLEASE GO STRAIGHT TO QUESTION 7

5. a) If you have had an episode of hypoglycaemia do you get warning symptoms? Yes ☐ No ☐
b) If **YES**, are you always aware? Yes ☐ No ☐

6. Have you had more than one episode of severe hypoglycaemia (requiring the assistance of another person) in the last 12 months? Yes ☐ No ☐
(Please only count episodes where you needed help. Do Not count episodes where you were given help but could have treated yourself.)

If **YES**, please provide the dates of the 2 most recent events.

DD	MM	YY		DD	MM	YY

7. Do you need to drive a vehicle fitted with special controls or automatic transmission? Yes ☐ No ☐

If **YES**, and you hold a full licence, please fill in the form D497 enclosed
(Please note that you must be able to control your vehicle safely at ALL times).

SECTION 2: About your Eyesight

1. Can you read a number plate from 20 metres and can you confirm that you have never been advised by an optician or doctor that your eyesight does not meet the minimum standards for driving? 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. a) Have you had laser treatment or injections into both eyes (or remaining eye if one eye only) for diabetic eye disease or another eye condition? *(Do not include corrective surgery for short sightedness)?* Yes ☐ No ☐

	MM	YY
b) If **YES**, please supply the date of your last treatment		

5. Do you have cataracts or any corneal dystrophies e.g. Fuchs in both eyes (or remaining eye if one eye only)? Yes ☐ No ☐

If you have answered YES to Q5 and have had your eyes tested within the last 6 months, please take the visual acuity certificate to your optician to complete. If you have answered NO, DO NOT return the opticians certificate.

	Confidential medical information	*Rev July 2012*

D497 form for Special Controls

If you have said **YES**, that you need to drive a vehicle fitted with special controls or automatic transmission, you must now fill in the parts of the D497 that are relevant to you. The E.C. code will be updated onto your record and appear on your licence. Please write to us if your circumstances change. We can change or remove codes.

You will also need to return both parts of your current driving licence if you have not already done so.

You should only complete this form if you hold a full driving licence. If you hold provisional entitlement or are applying for a provisional licence if you need special controls the specific codes will be updated when you pass your driving test.

D497 – Vehicle Controls

For CARS and, if appropriate, BUSES and LORRIES

- ☐ Automatic Transmission **78** (do not tick if driven by choice)
- ☐ Modified Transmission **10**
- ☐ Modified Clutch **15**
- ☐ Modified Braking System **20**
- ☐ Modified Control Layouts **35** (e.g. lights, switches, wipers)
- ☐ Modified Steering **40** (only tick if to overcome a disability)
- ☐ Modified Rear View Mirror **42**
- ☐ Modified Driver Seat **43**
- ☐ Modified Accelerator System **25**
- ☐ Combined Braking & Accelerator System **30**

D497 – Motorcycle Controls

- ☐ Single Operated Brake **44.1**
- ☐ Adjusted hand operated brake (front wheel) **44.2**
- ☐ Adjusted foot operated brake(back wheel) **44.3**
- ☐ Adjusted accelerator handle **44.4**
- ☐ Adjusted manual transmission and clutch **44.5**
- ☐ Adjusted rear view mirror(s) **44.6**
- ☐ Adjusted commands (lights, indicators etc) **44.7**
- ☐ Seat height- allows driver, In a seated position, to have contact with the ground **44.8**
- ☐ Only with sidecar **45**

Please tick the relevant box

- ☐ My licences is not enclosed because: ----------
- ☐ My licence is enclosed
- ☐ My licence has been returned to the DVLA

Declaration:

I confirm that I **need** the controls I have indicated

Signature _____ Date _____

You can get advice on special controls from the following
Website: www.direct.gov.uk/diableddrivers
And the Forum of Disabled Drivers Assessment Centres on 0800 559 36 36 (this telephone number is NOT for DVLA enquiries)

NAME	DOB	REF

DIABETIC VISUAL ACUITY CERTIFICATE

Rev Oct 12

FOR THE OPTOMETRIST: IMPORTANT INFORMATION

Your patient has informed us that they currently have cataracts 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**

- Please indicate (✓) 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: _____

On receipt a fee of £11.50 will be paid by DVLA – if you are VAT registered we will pay the fee and VAT a the standard rate on receipt of an invoice

Opticians Stamp

- Please enter the payee name below:

_____

	Yes	**No**
Is there an invoice to follow?	☐	☐
Is there a VAT invoice to follow?	☐	☐

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