

**PART A: ABOUT YOU**Please answer the questions on this form in **BLOCK CAPITAL** letters using **BLACK INK**Title: Surname: Date of Birth:
(Mr, Mrs, Miss, Other?)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:	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
Postcode:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

Consultants Name and Address

Title:	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
Postcode:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

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 seen
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

NAME	DOB	REF
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Questionnaire to assess your medical fitness to drive

Please tick the appropriate box(es) and answer all questions relating to your condition.

1. Have you had any form of seizure/epileptic attack? YES ☐ NO ☐

If you have ticked **YES**, go to **Question 1a**. If you have ticked **NO**, please go straight to **Question 2**.

1. a) Have you had more than one attack? YES ☐ NO ☐

- | | Awake | | | Sleep | | |
|---|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|
| | DD | MM | YY | DD | MM | YY |
| b) Date of first seizure/epileptic attack | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| c) Date of last seizure/epileptic attack | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |

- d) If you have suffered both awake and asleep attacks, please give the date of the first asleep attack after the last awake attack DD MM YY

- e) Are you currently taking or have you taken anti-epilepsy medication? YES ☐ NO ☐
If so, please give details of your medication below:

Medication name	Date Started	Date Stopped

- | | Doctor | | | Consultant | | |
|-----------------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|
| | DD | MM | YY | DD | MM | YY |
| f) Date of last appointment | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Date of next appointment | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |

DECLARATION

I agree to follow the advice of my doctors about any treatment for epilepsy, attend necessary appointments to monitor the condition and to inform DVLA should I experience further attacks.
(This section must be completed; if not, it will be returned to you. This may cause a delay with your case.)

Signature: _____ Date: _____

NAME	DOB	REF
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		YES	NO	DD	MM	YY
2.	Have you ever had a blackout?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3.	Have you ever had a pacemaker fitted?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
4.	Have you ever had a defibrillator fitted?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
5.	Have you ever had an insertion or upper end revision of a VP shunt?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

6. Please give details of any other medication, the date started and the date stopped if applicable

Medication name	Date started	Date stopped

		YES	NO
7.	Does the medication make you drowsy or confused throughout the day?	<input type="checkbox"/>	<input type="checkbox"/>

NAME	DOB	REF
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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
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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

