Confidential medical information

FEP1 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 seen

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(Rev Aug 11)

Questionnaire to assess your medical fitness to drive

If you are unsure of the answers, we advise you to discuss the form with your Doctor
Please tick the appropriate box(s) and answer all questions about your condition.

SECTION 1: EPILEPSY AND SOLITARY SEIZURES

Epileptic attacks may involve fits, convulsions or seizures. Epilepsy may also occur only as "auras" or strange feelings or taste, as absences or blank spells or as limb jerking or twitching. Epileptic episodes may occur during periods of. sleep or when awake

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

IF YOU HAVE TICKED NO, PLEASE PROCEED TO SECTION 2 OVERLEAF

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

	Awake DD	Awake MM	Awake YY	Sleep DD	Sleep MM	Sleep YY
1b. Date of first seizure/epileptic attack						
1c. Date of last seizure/epileptic attack						

1d. 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

1e. Have you had an alcohol/drug related seizure? **YES** ☐ **NO** ☐

If YES please give date(s) and details _____

_____

_____

1f. Please give details of all medication taken by you.

Medication name	Date started	Date stopped

1g. Does the medication make you drowsy or confused whilst driving? **YES** ☐ **NO** ☐

1h. Please give the date of your last and next appointment with your Doctor or Consultant

	Doctor DD	Doctor MM	Doctor YY	Consultant DD	Consultant MM	Consultant YY
Date of last appointment						
Date of next appointment						

DECLARATION : (only to be completed where there is a declaration of epilepsy).
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.

Signature _____ Date _____

NAME	DOB	REF

SECTION 2: BLACKOUTS

2. Have you ever had a blackout? **YES** ☐ **NO** ☐ **DATE** ☐☐☐☐☐☐

3. Have you had a pacemaker fitted? **YES** ☐ **NO** ☐ **DATE** ☐☐☐☐☐☐

4. Have you had a defibrillator fitted? **YES** ☐ **NO** ☐ **DATE** ☐☐☐☐☐☐

5. Have you had insertion or upper end revision of a VP shunt? **YES** ☐ **NO** ☐ **DATE**
   Date of insertion ☐☐☐☐☐☐
   Date of revision ☐☐☐☐☐☐

6. Please give the name of all the medication taken by you :

Medication name	Date started	Date stopped

7. Does the medication make you drowsy or confused whilst driving? **YES** ☐ **NO** ☐

8. Please give the date of your last and next appointment with your Doctor or Consultant

	Doctor DD	Doctor MM	Doctor YY	Consultant DD	Consultant MM	Consultant YY
Date of last appointment						
Date of next appointment						

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