Confidential medical information

B1 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 last seen

Questionnaire to assess your medical fitness to drive

1. Please tick the appropriate box (es) if you have ever suffered from any of the following:

		YES	NO		DD	MM	YY
1a	Subarachnoid haemorrhage.			When			
1b	Serious head injury.			When			
1c	Brain tumour.			Date of diagnosis			
1d	Acute Subdural Haematoma.			Date of diagnosis			
1e	Chronic Subdural Haematoma.			Date of diagnosis			
1f	Other condition.						

If **YES** please give details; _____

_____

_____

2. Please give the date of your last and next appointment with your doctor or Consultant.

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

3. Please give the name and dosage(the amount you take) of all the current medication taken by you:

Name of Medication	Dosage	Reason for taking

3a Does the medication make you drowsy or confused? **YES** ☐ **NO** ☐

4. Have you needed any of the following treatment(s)?

		YES	NO	DD	MM	YY
4a	Surgery such as craniotomy, burr hole.					
4b	Coil embolisation.					
4c	Insertion or removal of a VP shunt / external ventricular drain.					
4d	Radiotherapy and /or chemotheraphy.					

NAME:	DOB:	REF:
DRIVER NUMBER:		

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

5a. If **YES**, please give date of the blackout. **DD** **MM** **YY**

6. Have you ever had any form of epileptic attack? **YES** ☐ **NO** ☐

6a. Please give the date(s) of the epileptic attack(s) as follows

	AWAKE			SLEEP		
	DD	**MM**	**YY**	**DD**	**MM**	**YY**
Date of first epileptic attack						
Date of last epileptic attack						

6b. If you have suffered both awake and asleep attacks, please give the date of the first asleep attack after the last awake attack

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 which may cause a delay with your case)

Signature: _____ Date: _____

7. Do you suffer from **significant** memory problems? **YES** ☐ **NO** ☐

8. Do you suffer from episodes of confusion? **YES** ☐ **NO** ☐

9. Do you need help from another person with your day to day living? **YES** ☐ **NO** ☐

If **YES**, please give details of how they help you _____

_____

_____

10. Has your condition caused problems with your eyesight? (such as your visual field, double vision) **YES** ☐ **NO** ☐

If **YES,** please give details of how your eyesight is affected _____

_____

_____

11a. Do you <u>need</u> to drive a vehicle fitted with special controls or automatic transmission? ***If you answered NO to question 11a you DO NOT need to answer questions 11b and 11c.*** **YES** ☐ **NO** ☐

11b. Have you told us before that you need special controls or automatic transmission? ***If you answered YES to question 11b please answer question 11c.*** **YES** ☐ **NO** ☐

11c. Since your last licence was issued have you had any additional controls fitted to your vehicle? **YES** ☐ **NO** ☐

NAME:	DOB:	REF:
DRIVER NUMBER:		

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:
DRIVER NUMBER:		

Note: please fill in and return all pages (1-4) of this medical questionnaire and consent/declaration. If you do not give us all the information we need including the full name, address and telephone number of your GP/Consultant then there will be a delay with your case.

Please use the contact details below to return your filled in medical questionnaire to the Drivers Medical Group.

By Post

Drivers Medical Group
DVLA
Swansea
SA99 1DF

By fax

0845 850 0095

Please keep this page (5) for future reference.

Find out about DVLA's online services

Go to: www.gov.uk/browse/driving