Confidential medical information

STR1V 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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Questionnaire to assess your medical fitness to drive

REMINDER: You must not drive a car / motorcycle for 1 month from the date of your stroke / TIA.
You must not drive LGV / PCV vehicles for 12 months from the date of your stroke / TIA.

		Yes	No	Date	DD	MM	YY
1.	Have you suffered a TIA?						
2.	Have you suffered from a stroke?						

		Yes	No
2a.	Have you fully recovered?		

3. Please give the date of your last and next appointment with your doctor or consultant
(For this condition)

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

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

Name of Medication	Dosage	Reason for taking

4a. Does your medication make you drowsy or confused when driving? **YES** ☐ **NO** ☐

5. Have you needed rehabilitation ? **YES** ☐ **NO** ☐
(for example, physiotherapy, speech therapy or occupational therapy)

If **YES** please give details of ongoing treatment _____

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

6a. If **YES** please give the date of your first and last seizure / epileptic attack

	AWAKE			SLEEP		
	DD	MM	YY	DD	MM	YY
Date of first seizure / epileptic attack						
Date of last seizure / epileptic attack						

NAME	DOB	REF

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

7a. Do you suffer from episodes of confusion? **YES** ☐ **NO** ☐

7b. 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 _____

_____

_____

8. 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 _____

_____

_____

9. Do you have any persisting limb problems where 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 at ALL times)

NAME	DOB	REF

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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

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