FEP1 ONLINE

MEDICAL FITNESS TO DRIVE

Please answer the questions on this form in **BLOCK CAPITAL** letters using **BLACK INK**.
If you do not answer all the questions the form will be returned to you and cause a delay.

PART A: ABOUT YOU

Title: (Mr, Mrs, Miss, Other?)	
Surname:	
First Name(s):	
Date of Birth:	**DD** **MM** **YY**
Driver's No:	
Address:	
Telephone No: (Including dialling code)	Home Mobile
Email Address:	

PART B: ABOUT YOUR GP

Surname:	Dr
First Name:	
Surgery Address:	Postcode
Telephone No:	(Including dialling code)
Date last seen: (For this condition)	**DD** **MM** **YY**

PART C: ABOUT THE CONSULTANT YOU SEE FOR THIS CONDITION

Surname:
(Including title)

First Name:

Hospital Department:

Hospital Address:

Postcode

Telephone No: (Including dialling code)

Your Hospital No:

Date last seen: **DD** **MM** **YY**

If you have more than one Consultant please give their name & address on a separate sheet.

PART D: DETAILS OF CLINICS ATTENDING / ATTENDED

Clinics	Reason for attendance	Date last seen by GP DD MM YY	Date last seen by Consultant DD MM YY
Alcohol			
Cancer			
Cardiac			
Diabetes			
Drugs			
Neurological			
Psychiatry			
Sleep			
Vision			
Other clinic			

(Please give details below)

Questionnaire to assess your medical fitness to drive

FEP1
ONLINE
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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			Sleep		
	DD	**MM**	**YY**	**DD**	**MM**	**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. Please give details of all medication taken by you.

	Medication name	**Date started**	**Date stopped**
Seizure/ Epilepsy			

1f. Does the medication make you drowsy or confused? **YES** ☐ **NO** ☐

1g. 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						

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? **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

Rev Jul 07

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, and to inform my Doctor(s) of the outcome of the case where appropriate.

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: _____

Electronic Release of Information

DVLA is able to communicate by fax and by e-mail. We can use it to request medical information from your doctor(s). We can also use it to receive relevant medical information sent by your Doctors, Orthoptists or relevant personnel associated with any medical enquiry, medical examination or practical assessment that may be required.

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 you do not wish DVLA to communicate in this way or if we are unable to do so, conventional postage methods will be used instead. Should you wish to withdraw your agreement to communicate electronically by fax or e-mail at a later date such a request should be made by you in writing.

Do you agree to DVLA communicating with your Doctors, Orthoptists or relevant personnel by fax and 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

By Email

DVLA will always treat the information you send with the strictest confidence. However, as the security of the internet cannot be guaranteed, DVLA will be unable to send e-mails which contain personal information and advise that you also follow this policy.
If you feel at all concerned about emailing, please use another form of contact, e.g. post.

Email address
eftd@dvla.gsi.gov.uk