Driver and Vehicle Licensing Agency

For Medical Practitioners

At a glance Guide to the current Medical Standards of Fitness to Drive

Issued by
Drivers Medical Group
DVLA, Swansea

2013 Edition

The standards are reviewed following updated advice from the Secretary of State's Honorary Medical Advisory Panels. Revision of this information is scheduled following each round of meetings however, further critical updates may be made in the interim. This booklet mirrors the information held on the DVLA website www.dft.gov.uk/dvla/medical/ataglance.aspx.

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CONTENTS

	SUMMARY OF AMENDMENTS	
	INTRODUCTION	1-4
	Age limits	2
	Police, Ambulance and Health Service Vehicle Driver Licensing	2
	Taxi Licensing	2
	Seatbelt Exemption	2
	Contact Details	4
Chapter 1	NEUROLOGICAL DISORDERS	5-16
Appendix	Epilepsy Regulations	17-18
	Withdrawal of Anti-Epilepsy Medication & Provoked Seizures	19
Chapter 2	CARDIOVASCULAR DISORDER	20-27
Appendix	Medication	28
	Exercise Testing	28
	Stress Myocardial Perfusion Scan/Stress Echocardiography	28
	Coronary Angiography	28
Chapter 3	DIABETES MELLITUS	29-30
Appendix	Police, Ambulance and Health Service Vehicle Driver Licensing	31
	Qualifying Conditions for drivers on Insulin and Group 2 Entitlement:	31
	Information for drivers with Diabetes treated by non-insulin medication, diet or both (INF188/2).	32
	A Guide to Insulin Treated Diabetes and Driving (DIABINF).	33
Chapter 4	PSYCHIATRIC DISORDERS/DISORDER including:- Dementia, Learning Disability, Development & Behaviour Disorders	34-36
Appendix	Psychiatric Notes including:- Medication, Confidentiality & Patients under Section 17 of the Mental Health Act	37
Chapter 5	DRUG AND ALCOHOL MISUSE AND DEPENDENCE	38-41
Appendix	High Risk Offenders Scheme	39
Chapter 6	VISUAL DISORDERS	42-43
Appendix	Visual Fields and Perimetry	44
	Exceptional Cases for Group one (car) entitlement	44
	Peripheral Field Defect	44
Chapter 7	RENAL DISORDERS	45
	RESPIRATORY	45
Chapter 8	MISCELLANEOUS CONDITIONS	46-47
	OLDER DRIVERS	47
	IMPAIRMENT OF COGNITIVE FUNCTION	47
Appendix1	ADVICE FOR DISABLED DRIVERS	48
Appendix 2	DISABLED DRIVERS' ASSESSMENT CENTRES	49-51
	INDEX	52-53

-The applicant or licence holder must notify DVLA unless stated otherwise in the text

SUMMARY OF AMENDMENTS 2013 Edition - date of update as shown alongside entry

INTRODUCTION

Page 1 OPENING PARAGRAPH – Advice on where to find this information "NHSpurchasing.co.uk" has been removed as this no longer applies. **(March 2013)**

THE LEGAL BASIS FOR THE MEDICAL STANDARDS – Changes made to the 1st paragraph and 3rd bullet point. **(March 2013)**

Page 2 SEATBELT EXEMPTION – Product Ref and contact details have been updated. **(March 2013)**

Page 3 APPLICATION OF THE MECIAL STANDARDS – Changes made to the 4th paragraph. **(March 2013)**

CHAPTER 1 NEUROLOGICAL DISORDERS

Page 5 FIRST UNPROVOKED EPILEPTIC SEIZURE/ISOLATED SEIZURE – Title as been amended – Group 1 & 2 Entitlement - Additional information has been added to these sections. **(March 2013)**

EPILEPSY/EPILEPTIC SEIZURES – Group 1 Entitlement – An additional paragraph has been added to the end of this section. **(March 2013)**

Page 8 STROKE/TIA – Group 1 Entitlement - Last paragraph has been removed. **(March 2013)**

Page 11 MALIGNANT TUMOURS:

SUPRATENTORIAL – GRADE III AND IV GLIOMAS, METASTATIC DEPOSIT(S) "AND PRIMARY CNS LYMPHOMAS" has been added to this heading. **(March 2013)**

INFRATENTORIAL TUMOURS – HIGH GRADE EPENDYMOMAS, OTHER PRIMARY MALIGNANT BRAIN TUMOURS "AND PRIMARY CNS LYMPHOMAS" has been added to this heading. **(March 2013)**

Page 12 TRAUMATIC BRAIN INJURY replaces the heading "Significant Head Injury**". (March 2013)**

SPONTANEOUS ACUTE SUBDURAL HAEMATOMA – Group 2 Entitlement – Wording has been revised. **(March 2013)**

2. (a) INTRACRANIAL ANEURYSM – A note has been added under the heading of this section - Group1 & 2 Entitlement - Both sections have been revised. **(March 2013)**

Page 13 (b) INTRACRANIAL ANEURYSM - NO TREATMENT – Group1 Entitlement - Wording has been revised. **(March 2013)**

(c) TRULY INCIDENTAL FINDINGS OF INTRACRANIAL ANEURYSM – Group 1Entitlement – Wording has been revised. **(March 2013)**

Page 14 ARTERIOVENOUS MALFORMATION - A note has been added under the heading of this section. **(March 2013)**

Page 16 NEUROENDOSCOPIC PROCEDURES – Group 2Entitlement – Wording has been revised. **(March 2013)**

Page 17-18 THE CURRENT EPILEPSY REGULATIONS FOR GROUP 1 AND GROUP 2 ENTITLEMENT – This section has been revised **(March 2013)**

APPENDIX – GUIDANCE FOR CLINICIANS ADVISING PATIENTS TO SURRENDER THEIR DRIVING LICENCE IN THE CASE OF BREAK-THROUGH SEIZURES IN THOSE WITH ESTABLISHED EPILEPSY – This section has been removed. **(March 2013)**

Page 19 GUIDANCE FOR WITHDRAWAL OF ANTI-EPILEPSY MEDICATION BEING WITHDRAWN ON SPECIFIC MEDICAL ADVICE – 3rd sentence of the first paragraph has been removed. **(March 2013)**

CHAPTER 3 DIABETES MELLITUS

Page 29 INSULIN TREATED – Group 1 & 2 Entitlement – Wording has been revised in 3rd bullet point of each section. **(March & May 2013)**

Page 30 MANAGED BY TABLETS OTHER THAN THOSE ABOVE OR BY NON-INSULIN MEDICATION – Group 2 Entitlement – 2nd paragraph has been removed **(May 2013)**

Page 32 INF188/2 – WHAT YOU NEED TO TELL US ABOUT – Wording in the 5th bullet point "or Anti-VEGF treatment" has been removed. **(March 2013)**

Page 33 DIABINF – DRIVERS WITH INSULIN TREATED DIABETES ARE ADVISED TO TAKE THE FOLLOWING PRECAUTIONS. – Wording in 1st, 4th and 5th bullet points have been revised. **(March 2013)**

Page 33 DIABINF – DRIVERS WITH INSULIN TREATED DIABETES ARE ADVISED TO TAKE THE FOLLOWING PRECAUTIONS. – Wording added in 1st bullet point. **(May 2013)**

CHAPTER 4 PSYCHIATRIC DISORDERS

Page 36 MILD COGNITIVE IMPAIRMENT (MCI) – Group 1 & 2 Entitlement - Wording has been revised**. (March 2013)**

Page 37 APPENDIX - PSYCHIATRIC NOTES - PATIENTS UNDER SECTION 17 OF THE MENTAL HEALTH ACT- Wording has been revised. **(March 2013)**

CHAPTER 6 VISUAL DISORDERS

Page 42 ACUITY – Group 2 Entitlement – wording in para 1 revised. (**March 2013**)
MONOCULAR VISION – Group 1 Entitlement – wording revised. (**March 2013**)

Page 43 VISUAL FIELD DEFECTS – Group 2 Entitlement – wording revised. (**March 2013**)

Page 44 APPENDIX – Exceptional Cases – 2 further bullet points added. (**March 2013**)

CHAPTER 7 RESPIRATORY DISORDERS

Page 45 This chapter title has now been amended as the information on sleep disorders has been removed and information on this subject can be found under Chapter 8 "Excessive Sleepiness". **(March 2013)**

CHAPTER 8 MISCELLANEOUS CONDITIONS

Page 46 EXCESSIVE SLEEPINESS – New Entry. **(March 2013)**

BRAIN TUMOURS – Entry has been removed. **(March 2013)**

LUNG CANCER – Entry has been removed. **(March 2013)**

CANCERS NOT AREADY COVERED IN EARLIER SECTIONS – Title replaces "OTHER CANCERS". **(March 2013)**

APPENDIX 2 DISABLED DRIVERS ASSESSMENT CENTRE

Pages 49-50 Various details in this section have been amended where appropriate. **(March 2013)**

This booklet is only accurate at the time of publication.

Please see the DVLA website for the most up-to-date information www.dft.gov.uk/dvla/medical/ataglance.aspx

Revised March 2013

AT A GLANCE BOOKLET - INTRODUCTION

This publication summarises the national medical guidelines of fitness to drive and is available to doctors and health care professionals. It can be found specifically through EMIS, INPS secure GP Medical Information Systems. It is also publicly available on the DVLA website at http://www.dft.gov.uk/dvla/medical.aspx. Hard copies of the booklet are available on request for a fee of £4.50 (cheques made payable to DVLA Swansea) from Drivers Medical Group, DMDG, DVLA, Swansea SA99 1DF. Telephone 01792 782336 (answer machine for Medical Professionals Only).

The information in the booklet is intended to assist doctors in advising their patients whether or not they should inform DVLA of their medical condition and what the outcome of medical enquiries is likely to be.

In the interests of road safety, those who suffer from a medical condition likely to cause a sudden disabling event at the wheel or who are unable to safely control their vehicle from any other cause, should not drive.

- **Compilation of the Guidelines.**

These guidelines represent the interpretation and application of the law in relation to fitness to drive following advice from the Secretary of State's Honorary Medical Advisory Panels. The Panels consist of doctors eminent in the respective fields of Cardiology, Neurology, Diabetes, Vision, Alcohol/Substance Abuse and Psychiatry together with lay members.

The Panels meet twice yearly and the standards are reviewed and updated where indicated. **This booklet is, therefore, only accurate at the time of publication.** Please see the DVLA website for the most up-to-date information www.dft.gov.uk/dvla/medical/ataglance.aspx .

It is also emphasised that this booklet is for use as guidance only. Whilst it provides some idea of the anticipated outcome of a medical enquiry, the specific medical factors of each case will be considered before an individual licensing decision is reached.

- **The Legal basis for the medical standards.**

The Secretary of State for Transport acting through the DVLA, has the responsibility to ensure that all licence holders are fit to drive.

The legal basis of fitness to drive lies in the 2nd EC Directive on driving licences (91/439/EEC), which came into effect in the UK in January 1997, the Road Traffic Act 1988 and the Motor Vehicles (Driving Licences) Regulations 1999. The 2nd Driving Licence Directive was amended by Directive 2009/112/EC with effect from 15.9.09 and these amendments came into force on 15.9.2010.

Section 92 of the Road Traffic Act 1988 refers to prescribed, relevant and prospective disabilities.

- A prescribed disability is one that is a legal bar to the holding of the licence. Certain statutory conditions, defined in regulation, may need to be met. An example is epilepsy.
- A relevant disability is any medical condition that is likely to render the person a source of danger while driving. An example is a visual field defect.
- A prospective disability is any medical condition, which, because of its progressive or intermittent nature may develop into a prescribed or relevant disability in the course of time. Examples are Parkinson's disease and dementia. A driver with a prospective disability may normally only hold a driving licence subject to medical review in one, two or three years.

Sections 92 and 93 of The Road Traffic Act 1988 also cover drivers with physical disabilities who require adaptations to their vehicle to ensure its safe control. The adaptations required are now coded and entered on the licence.
(**See** Appendices 1 **&** 2)

- **Licence Groups**

The medical standards refer to Group 1 and Group 2 licence holders.

Group 1 includes motor cars and motor cycles.

Group 2 includes large lorries (category C) and buses (category D). The medical standards for Group 2 drivers are very much higher than those for Group 1 because of the size and weight of the vehicle. This also reflects the higher risk caused by the length of time the driver may spend at the wheel in the course of his/her occupation.

All drivers who obtained entitlement to Group 1, category B (motor car) before 1 January 1997 have additional entitlement to category **C1 and D1.** C1 is a medium size lorry of weight between 3.5 and 7.5 tonne. D1 is a minibus of between 9 and 16 seats, not for hire or reward.

Holders of C1 and D1 entitlement retain the entitlement until their licence expires or it is medically revoked. On subsequent renewal the higher medical standards applicable to Group 2 will apply.

Under certain circumstances volunteer drivers can drive a minibus of up to 16 seats without having to obtain category D1 entitlement. Individuals should consult DVLA for a detailed fact sheet.

- **Age limits**

Group1: Licences are normally issued valid until age 70 years (Till 70 licence) unless restricted to a shorter duration for medical reasons as indicated above. There is no upper limit but after age 70 renewal is necessary every 3 years. All licence applications require a medical self declaration by the applicant.

A person in receipt of the higher rate of the Mobility Component of Disability Living Allowance may apply for a licence (Group 1 category B) from age 16 years, instead of the usual lower age limit of 17 years.

Group 2: Excepting in the armed forces and certain PCV licences, Group 2 licences, lorries (category C) or buses (category D) are normally issued at age 21 years and are valid till age 45 years but may be issued from age 18 where the licence holder has obtained or is undertaking a Certificate of Professional Competence (CPC) initial qualification. Group 2 licences are renewable thereafter every five years to age 65 years unless restricted to a shorter period for medical reasons.

From age 65 years Group 2 licences are renewable annually without upper age limit. All Group 2 licence applications must be accompanied by a completed medical application form D4.

- **Police, Ambulance and Health Service Vehicle Driver Licensing ***

Responsibility for determining the standards, including medical requirements, to be applied to police, ambulance and health service vehicle drivers, over and above the driver licensing requirements rests with the individual Police Force, with the NHS Trust, Primary Care Trust or Health Service body in each area. The Secretary of State's Honorary Medical Advisory Panel on Diabetes and Driving has issued advice regarding insulin treated diabetes and the driving of emergency vehicles, which can be found in the Appendix at the end of Chapter 3.

- **Taxi Licensing ***

The House of Commons Transport Select Committee on Taxis and Private Hire Vehicles recommended in February 1995 that taxi licence applicants should pass a medical examination before such a licence could be granted.

Responsibility for determining the standards, including medical requirements, to be applied to taxi drivers, over and above the driver licensing requirements, rests with the Transport for London in the Metropolitan area and the Local Authority in all others areas. Current best practice advice is contained in the booklet "Fitness to Drive": A Guide for Health Professionals published on behalf of the Department by The Royal Society of Medicine Press Limited ((RSM) in 2006. This recommended that the Group 2 medical standards applied by DVLA in relation to bus and lorry drivers, should also be applied by local authorities to taxi drivers.

*Caveat: The advice of the Panels on the interpretation of EC and UK legislation, and its appropriate application, is made within the context of driver licensing and the DVLA process. It is for others to decide whether or how those recommendations should be interpreted for their own areas of interest, in the knowledge of their specific circumstances.

- **Seatbelt Exemption**

There is overwhelming evidence to show that seatbelts prevent death and serious injury in road traffic accidents. For this reason, the law makes it compulsory for car occupants to wear seatbelts, where fitted. One exception allowed by legislation is if the car occupant has a valid exemption certificate, which confirms it is inadvisable on medical grounds to wear a seatbelt. The certificates are issued by medical practitioners, who will need to consider very carefully the reasons for exemption, in view of the weight of evidence in favour of seatbelts. Medical practitioners can obtain supplies of ***Certificate of Exemption from Compulsory Seat Belt Wearing*** (product Ref PPU4272) and the guidance leaflet ***Medical Exemption from Compulsory Seat Belt Wearing*** by phoning 0300 123 1102. The certificates come in booklets of five. Further enquiries should be made to: Department for Transport, Road Safety Division 1, Zone 3/21, Great Minster House, 33 Horseferry Road, London SW1P 4DR; Tel: 020 7944 2027; Email: andrewb.smith@dft.gsi.gov.uk .

- **Impairment due to Medication**

It is an offence to drive or attempt to drive whilst unfit through drugs; the law does not distinguish between illegal drugs and prescribed medication. Some prescription drugs and over the counter medicines can affect the skills needed to drive safely because they may cause drowsiness, impaired judgement or other adverse effects. Health professionals prescribing or dispensing medication should consider the risk associated with that medicine, or combination of medicines, and driving and take the opportunity to appropriately advise their patients.

- **Impairment Secondary to Multiple Medical Conditions**

In some cases, a combination of multiple medical conditions, each insufficient in itself to disqualify from driving, may produce an annual risk of incapacitation unacceptable for either a Group 1 or a Group 2 licence, or render a person a likely source of danger.

When such a combination of risk factors is felt to be present, the patient should be advised not to drive. The health professional may seek clarification from the DVLA.

- **Notification to DVLA**

It is the duty of the licence holder or licence applicant to notify DVLA of any medical condition, which may affect safe driving. On occasions however, there are circumstances in which the licence holder cannot, or will not do so.

The GMC has issued clear guidelines* applicable to such circumstances, which state:

"1. The driver is legally responsible for informing the DVLA about such a condition or treatment. However, if a patient has such a condition, you should explain to the patient:

   (a) that the condition may affect their ability to drive (if the patient is incapable of understanding this advice, for example, because of dementia, you should inform the DVLA immediately), and

   (b) that they have a legal duty to inform the DVLA about the condition.

2. If a patient refuses to accept the diagnosis, or the effect of the condition on their ability to drive, you can suggest that they seek a second opinion, and help arrange for them to do so. You should advise the patient not to drive in the meantime.

3. If a patient continues to drive when they may not be fit to do so, you should make every reasonable effort to persuade them to stop. As long as the patient agrees, you may discuss your concerns with their relatives, friends or carers.

4. If you do not manage to persuade the patient to stop driving, or you discover that they are continuing to drive against your advice, you should contact the DVLA immediately and disclose any relevant medical information, in confidence, to the medical adviser.

5. Before contacting the DVLA you should try to inform the patient of your decision to disclose personal information. You should then also inform the patient in writing once you have done so."

*(*Reproduced with kind permission of the General Medical Council)* -Full information on GMC guidelines can be viewed on www.gmc-uk.org

- **Application of the Medical Standards**

Once the licence holder has informed DVLA of their condition and provided consent, medical enquiries will be made, as required. The Secretary of State, in practice DVLA, is unable to make a licensing decision until all the available relevant medical information has been considered. It may therefore be a relatively lengthy process to obtain all necessary reports and, during this period, the licence holder normally retains legal entitlement to drive under Section 88 of the Road Traffic Act 1988.

However, by reference to this booklet, the doctor in charge of their care should be able to advise the driver whether or not it is appropriate for them to continue to drive during this period. Patients may be reminded that if they choose to ignore medical advice to cease driving, there could be consequences with respect to their insurance cover. Doctors are advised to document formally and clearly in the notes the advice that has been given.

Where the licence has been revoked previously for medical reasons then Section 88 of the Road Traffic Act 1988 entitlement does not apply.

On receipt of all the required medical evidence, DVLA will decide whether or not the driver or applicant can satisfy the national medical guidelines and the requirements of the law. A licence is accordingly issued or revoked/refused.

Any doctor who is asked for an opinion about a patient's fitness to drive should explain the likely outcome by reference to this booklet but refer the licence holder/applicant to Drivers Medical Group, DVLA for a decision.

Important Note.

Throughout the publication reference is made to notification not being required where specified. For these conditions and others not mentioned in the text this is generally the case but very rarely, the conditions may be associated with continuing symptoms that may affect consciousness, attention or the physical ability to control the vehicle. In addition, regular ongoing therapeutic use of medication which causes relevant impairment(s) may be incompatible with driving. In these rare instances, the driver should be advised to report the condition and symptoms of concern to DVLA.

- **Driving after surgery**

Drivers do not need to notify DVLA unless the medical conditions likely to affect safe driving persist for longer than 3 months after the date of surgery (but please see Neurological and Cardiovascular Disorders Sections for exceptions).

Therefore, licence holders wishing to drive after surgery should establish with their own doctors when it is safe to do so.

Any decision regarding returning to driving must take into account several issues. These include recovery from the surgical procedure, recovery from anaesthesia, the distracting effect of pain, impairment due to analgesia (sedation and cognitive impairment), as well as any physical restrictions due to the surgery, underlying condition, or other co-morbid conditions.

It is the responsibility of the driver to ensure that he/she is in control of the vehicle at all times and to be able to demonstrate that is so, if stopped by the police. Drivers should check their insurance policy before returning to drive after surgery.

- **Further advice on fitness to drive**

Doctors or other health-care professionals may enquire in writing, or may speak to one of the medical advisers during office hours, to seek advice about a particular driver (identified by a unique reference number) or about fitness to drive in general. After office hours there is an answer-phone and it would be helpful if doctors could indicate a time when it would be convenient for a return call.

In addition, DVLA's topic specific medical enquiry forms are available on the website and may be downloaded in pdf format. These may be used by drivers/applicants to notify DVLA of their condition, to support an application and to provide consent for medical enquiry. Currently, the completed forms must be forwarded to the Agency by post.

Address for enquiries in England, Scotland and Wales

The Medical Adviser
Drivers Medical Group
DVLA
Longview Road
Morriston
SWANSEA SA99 1TU
Tel: 01792 782337 (Medical Professionals Only)
Email: medadviser@dvla.gsi.gov.uk **(Medical Professionals Only)**

Address for enquiries in N. Ireland

Driver and Vehicle Licensing
Northern Ireland
Castlerock Road
COLERAINE
BT51 3TB
Tel: 028 703 41369

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This document may be cited in part or in whole for the specific guidance of doctors and patients. However the document must not be reproduced in part or in whole for commercial purposes.

This booklet is published by the Department for Transport. It describes the law relating to medical aspects of driver licensing. In particular, it advises members of the medical profession on the medical standards which need to be met by individuals to hold licences to drive various categories of vehicle. The Department has prepared the document on the advice of its Advisory Panels of medical specialists.

The document provides the basis on which members of the medical profession advise individuals on whether any particular condition could affect their driving entitlement. It is the responsibility of the individual to report the condition to the DVLA in Swansea. DVLA will then conduct an assessment to see if the individual's driving entitlement may continue or whether it should be changed in any way. (For example, entitlement could be permitted for a shorter period only, typically three years, after which a further medical assessment would be carried out by DVLA).

CHAPTER 1
NEUROLOGICAL DISORDERS

NEUROLOGICAL DISORDERS	GROUP 1 ENTITLEMENT ODL – CAR, M/CYCLE	GROUP 2 ENTITLEMENT VOC – LGV/PCV (LORRY/BUS)
EPILEPSY Epileptic attacks are the most frequent medical cause of collapse at the wheel. **NB**: If within a 24 hour period more than one epileptic attack occurs, these are treated as a "single event" for the purpose of applying the epilepsy regulations. Epilepsy includes all events: major, minor and auras.	**The Epilepsy Regulations Apply**. Provided a licence holder/applicant is able to satisfy the regulations, a 3-year licence will be issued normally. Till 70 licence restored if seizure-free for 5 years since the last attack with medication if necessary in the absence of any other disqualifying condition. (**See** Appendix **to this Chapter for full regulations**)	Regulations require a driver to remain seizure-free for 10 years since the last attack without anticonvulsant medication.
FIRST UNPROVOKED EPILEPTIC SEIZURE/ISOLATED SEIZURE	6 months off driving from the date of the seizure. If there are clinical factors or investigation results which suggest an unacceptably high risk of a further seizure, ie. 20% or greater per annum, this will be 12 months off driving from the date of the seizure.	5 years off driving from the date of the seizure if the licence holder has undergone recent assessment by a neurologist and there are no clinical factors or investigation results (eg. EEG, brain scan) which indicate that the risk of a further seizure is greater than 2% per annum. They should have taken no anti-epilepsy medication throughout the 5-year period immediately prior to the granting of the licence. If risk of further seizure is greater than 2% per annum Group 2 epilepsy regulations apply.
The following features are consistent with a person having a good prognosis: • No relevant structural abnormality of the brain on imaging; • No definite epileptiform activity on EEG; • Support of the neurologist; • Seizure risk considered to be 2% or less per annum for vocational licensing and 20% or less per annum for ordinary driving licensing.		
EPILEPSY/EPILEPTIC SEIZURES General guidance for ALL neurosurgical conditions if associated with epilepsy or epileptic seizures	In all cases where epilepsy has been diagnosed, the epilepsy regulations apply. These cases will include all cases of single seizure where a primary cerebral cause is present and the liability to recurrence cannot be excluded. An exception may be made when seizures occur at the time of an acute head injury or intracranial surgery. When seizures occur at the time of intracranial venous thrombosis, 6 months is required, free from attacks, before resuming driving.	In all cases where a "liability to epileptic seizures" either primary or secondary has been diagnosed, the specific epilepsy regulation for this group applies. The only exception is a seizure occurring immediately at the time of an acute head injury or intracranial surgery, and not thereafter and/or where no liability to seizure has been demonstrated. Following head injury or intracranial surgery, the risk of seizure must have fallen to no greater than 2% per annum before returning to vocational driving.
WITHDRAWAL OF ANTI-EPILEPSY MEDICATION AND DRIVING	**See** Appendix **to this Chapter for full details.**	**See** Appendix **to this Chapter for full details.**
PROVOKED SEIZURES (apart from alcohol or illicit drug misuse)	**See** Appendix **to this Chapter for full details.**	**See** Appendix **to this Chapter for full details.**
NON EPILEPTIC SEIZURE ATTACKS	Can be considered once attacks have been satisfactory controlled and there are no relevant mental health issues.	Can be considered once attacks have been satisfactory controlled and there are no relevant mental health issues.

See Appendix at end of this Chapter for Epilepsy Regulations

LOSS OF CONSCIOUSNESS/LOSS OF OR ALTERED AWARENESS

** Excluding Cough Syncope ** (See Chapter 7)

A full history is imperative to include pre-morbid history, prodromal symptoms, period of time unconscious, degree of amnesia and confusion on recovery.

A neurological cause, for example, epilepsy, subarachnoid haemorrhage , can often be identified by the history, examination and the appropriate referral made. The relevant DVLA guidelines will then apply.

80% of all cases have a cardiovascular cause and again, these can be determined by history, examination and ECG. Investigate and treat accordingly and use the relevant DVLA guidelines.

The remaining cases can be classified under five categories in the FOLLOWING TABLE*:*

NEUROLOGICAL DISORDERS	GROUP 1 ENTITLEMENT ODL – CAR, M/CYCLE	GROUP 2 ENTITLEMENT VOC – LGV/PCV (LORRY/BUS)
1. Reflex Vasovagal Syncope Definite provocational factors with associated prodromal symptoms and which are unlikely to occur whilst sitting or lying. Benign in nature. If recurrent, will need to check the "3 Ps" apply on each occasion (provocation/prodrome/postural). (**If not see Number 6 below**).	No driving restrictions. DVLA need not be notified.	No driving restrictions DVLA need not be notified NB Cough Syncope see Chapter 7
2.Solitary loss of consciousness/ loss of or altered awareness likely to be unexplained syncope but with a high probability of reflex vasovagal syncope. These have no clinical evidence of structural heart disease and a normal ECG.	No driving restrictions. DVLA need not be notified.	Can drive 3 months after the event. NB Cough Syncope see Chapter 7
3. Solitary loss of consciousness/ loss of or altered awareness likely to be cardiovascular in origin (excluding 1 or 2). Factors indicating high risk: (a) abnormal ECG (b) clinical evidence of structural heart disease (c) syncope causing injury, occurring at the wheel or whilst sitting or lying (d) more than one episode in previous six months. Further investigations such as ambulatory ECG (48hrs), echocardiography and exercise testing may be indicated after specialist opinion has been sought. ****for** Pacemakers **see Chapter 2**	Licence refused/revoked for 6 months if no cause identified. Can drive 4 weeks after the event if the cause has been identified and treated.	Licence refused/revoked for 12 months if no cause identified. Can drive 3 months after the event if the cause has been identified and treated. NB Cough Syncope see Chapter 7

See Appendix at end of this Chapter

NEUROLOGICAL DISORDERS	GROUP 1 ENTITLEMENT ODL – CAR, M/CYCLE	GROUP 2 ENTITLEMENT VOC – LGV/PCV (LORRY/BUS)
4. Solitary loss of consciousness/loss of or altered awareness **with** seizure markers This category is for those where there is a strong clinical suspicion of a seizure but no definite evidence. Factors to be considered: - without reliable prodromal symptoms - Unconsciousness for more than 5 minutes. - amnesia longer than 5 minutes - injury - tongue biting - incontinence - remain conscious but with confused behaviour - headache post attack	6 months off driving from the date of an episode of loss of consciousness/loss of or altered awareness. However, if a person has a previous history of epilepsy or an isolated seizure, 12 months' freedom from any further episode of loss of consciousness with seizure markers must be attained. If a person suffers recurrent episodes of loss of consciousness with seizure markers, 12 months' freedom from such episodes must be attained.	5 years off driving from the date of an episode if the licence holder has undergone assessment by an appropriate specialist and no relevant abnormality has been identified on investigation, for example EEG and brain scan, where indicated.
5. Solitary loss of consciousness/loss of or altered awareness **with no** clinical pointers. This category will have had appropriate neurological **and** cardiac opinion and investigations but with no abnormality detected.	Licence refused /revoked for 6 months	Licence refused /revoked for 1 year
6. Two or more episodes loss of consciousness/loss of or altered awareness without reliable prodromal symptoms.	Licence revoked or refused for 12 months or until the risk has been reduced to <20% per annum	Licence revoked or refused for 5 years or until the risk has been reduced to less than 2% per annum

NEUROLOGICAL DISORDERS	GROUP 1 ENTITLEMENT ODL – CAR, M/CYCLE	GROUP 2 ENTITLEMENT VOC – LGV/PCV (LORRY/BUS)
PRIMARY/CENTRAL HYPERSOMNIAS: including Narcoleptic syndromes	Cease driving on diagnosis. Licence may be issued when there has been a period of between 3 and 6 months satisfactory control of symptoms with appropriate treatment. If not on appropriate treatment, licensing may be allowed subject to a satisfactory objective assessment of maintained wakefulness, such as the Osler test.	Cease driving on diagnosis. Licence may be issued subject to specialist assessment and a satisfactory objective assessment of maintained wakefulness, such as the Osler test.
CHRONIC NEUROLOGICAL DISORDERS e.g. Multiple sclerosis, motor neurone disease, etc which may affect vehicle control because of impairment of co-ordination and muscle power. See also Appendix 1 for information on Driving assessment for "disabled drivers".	Providing medical assessment confirms that driving performance is not impaired, can be licensed. a 1, 2 or 3 year licence may be required. Should the driver require a restriction to certain controls, the law requires this to be specified on the licence.	Licence refused or revoked if condition is progressive or disabling. If driving would not be impaired and condition stable, can be considered for licensing subject to satisfactory reports and annual review (individual basis).

See Appendix at end of this Chapter

NEUROLOGICAL DISORDERS	GROUP 1 ENTITLEMENT ODL - CAR, M/CYCLE	GROUP 2 ENTITLEMENT VOC – LGV/PCV (LORRY/BUS)
PARKINSON'S DISEASE	Licence refused or revoked if condition is disabling and/ or there is clinically significant variability in motor function. If driving would not be impaired, can be considered for licensing subject to satisfactory reports. Licence may be issued subject to regular review	Licence refused or revoked if condition is disabling and/or there is clinically significant variability in motor function. If driving would not be impaired, can be considered for licensing subject to individual assessment. Licence may be issued subject to annual review
LIABILITY TO SUDDEN ATTACKS OF UNPROVOKED OR UNPRECIPITATED DISABLING GIDDINESS	**Cease driving on diagnosis.** Driving will be permitted when satisfactory control of symptoms achieved. If remains asymptomatic, Till 70licence restored.	Licence refused or revoked if condition sudden and disabling. Consider underlying diagnosis and if likely to cause recurrent attacks, must be symptom-free and completely controlled for 1 year from last attack before re-application.
STROKE/TIA	**TIA** **No need to notify DVLA** **Must not drive for 1 month.** **STROKE** **Must not drive for 1 month**. May resume driving after this period if the clinical recovery is satisfactory. There is no need to notify DVLA **unless** there is residual neurological deficit 1 month after the episode; in particular, visual field defects, cognitive defects and impaired limb function. Minor limb weakness alone will not require notification unless restriction to certain types of vehicle or vehicles with adapted controls is needed. Adaptations may be able to overcome severe physical impairment (**See** Appendices 1 **&** 2). Seizures occurring at the time of a stroke/TIA or in the ensuing 24 hours may be treated as provoked for licensing purposes in the absence of any previous seizure history or previous cerebral pathology.	Licence refused or revoked for 1 year following a stroke or TIA. Can be considered for licensing after this period provided that there is no debarring residual impairment likely to affect safe driving and there are no other significant risk factors. Licensing may be subject to satisfactory medical reports including exercise ECG testing. Where there is imaging evidence of less than 50% carotid artery stenosis and no previous history of cardiovascular disease Group 2 licensing may be allowed without the need for functional cardiac assessment. However, if there are recurrent TIAs or strokes functional cardiac testing shall still be required.

See Appendix at end of this Chapter

NEUROLOGICAL DISORDERS	**GROUP 1 ENTITLEMENT ODL - CAR, M/CYCLE**	**GROUP 2 ENTITLEMENT VOC – LGV/PCV (LORRY/BUS)**
ACUTE ENCEPHALITIC ILLNESSES AND MENINGITIS Including Limbic Encephalitis associated with seizures.	1) If no seizure(s), may resume driving when clinical recovery is complete. Only need notify DVLA if there is residual disability. 2) If associated with seizures during acute febrile illness, licence refused or revoked for 6 months from the date of seizure(s). Till 70 licence then reissued. 3) If associated with seizure(s) during or after convalescence, will be required to meet **epilepsy regulations.** **See** Appendix **to this Chapter for full regulations.**	1) As for Group 1 provided no residual disabling symptoms, and clinical recovery is complete. 2) **Must stop driving** and notify DVLA. (a) Meningitis – 5 years free from seizures without anticonvulsant medication. (b) Encephalitis - 10 years free from seizures without anticonvulsant medication. 3) **Must stop driving,** notify DVLA and meet current **epilepsy regulations** before driving resumes. **See** Appendix **to this Chapter for full regulations.**
TRANSIENT GLOBAL AMNESIA	Provided epilepsy, any sequelae from head injury and other causes of altered awareness have been excluded, no restriction on driving. DVLA need not be notified. Till 70 licence retained.	A single confirmed episode is not a bar to driving; the licence may be retained. If two or more episodes occur, driving should cease and DVLA notified. Specialist assessment required to exclude all other causes of altered awareness.
ARACHNOID CYSTS Asymptomatic and untreated Craniotomy and/or endoscopic treatment	 No restriction 6 months off.	 No restriction Can drive 2 years after treatment, provided that there is no debarring residual impairment likely to affect safe driving.
COLLOID CYSTS: Asymptomatic and untreated Craniotomy and/or endoscopic treatment	 No restriction. 6 months off.	 No restriction unless prescribed prophylactic medication for seizures when there should be individual assessment. Can drive 2 years after treatment, provided that there is no debarring residual impairment likely to affect safe driving.
PITUITARY TUMOUR CRANIOTOMY TRANSPHENOIDAL SURGERY/OTHER TREATMENT (e.g. drugs, radiotherapy) or Untreated	Provided no visual field defect (if visual field loss, see Vision section): • 6 months off driving. • Drive on recovery	Provided no visual field defect (if visual field loss, see Vision section) • 2 years off driving • Can drive when there is no debarring residual impairment likely to affect safe driving.

NEUROLOGICAL DISORDERS	**GROUP 1 ENTITLEMENT ODL - CAR, M/CYCLE**	**GROUP 2 ENTITLEMENT VOC – LGV/PCV (LORRY/BUS)**
BENIGN SUPRATENTORIAL TUMOUR e.g. WHO GRADE 1 MENINGIOMAS		
TREATMENT BY CRANIOTOMY	6 months off driving when there is no debarring residual impairment likely to affect safe driving. Epilepsy regulations apply if relevant history of seizure(s).	Refusal or revocation. In the absence of any seizures, re-licensing can be considered 5 years after surgery, with evidence of complete removal. If tumour is associated with seizures, 10 years freedom from seizures without anti-epilepsy drugs following surgery is required. Specialist assessment may be required.
TREATMENT WITH STEREOTACTIC RADIOSURGERY	1month off driving; can drive when there is no debarring residual impairment likely to affect safe driving. Epilepsy regulations apply if relevant history of seizure(s).	Can be considered 3 years after the completion of the primary treatment of the tumour, provided that there is evidence on imaging of stability. If tumour association with seizure(s), 10 years' freedom from seizures without anti-epilepsy drugs following surgery is required. Specialist assessment may be required.
TREATMENT WITH FRACTIONATED RADIOTHERAPY	Can drive on completion of treatment, provided that there is no debarring residual impairment likely to affect safe driving Epilepsy regulations apply if relevant history of seizure(s).	As above.
WHO GRADE II MENINGIOMAS TREATED BY CRANIOTOMY AND/OR RADIOSURGERY AND/OR RADIOTHERAPY:	Requires 1 year off driving, dating from the completion of treatment. Epilepsy regulations apply if relevant history of seizure(s).	Refusal or revocation. In the absence of any seizures, re-licensing can be considered 5 years after surgery, with evidence of complete removal. If tumour is associated with seizure(s), 10 years freedom from seizures without anti-epilepsy drugs following surgery is required. Specialist assessment may be required.
Asymptomatic, incidental meningiomas: untreated	Retain	Refusal/revocation until 2 scans 12 months apart showing no growth. If growth, individual Panel assessment. Annual review licence.

See Appendix at end of this Chapter

NEUROLOGICAL DISORDERS	GROUP 1 ENTITLEMENT ODL - CAR, M/CYCLE	GROUP 2 ENTITLEMENT VOC – LGV/PCV (LORRY/BUS)
BENIGN INFRATENTORIAL TUMOURS e.g. meningioma with surgery by craniotomy with or without radiotherapy.	Drive on recovery.	As for Group 1 provided that there is no debarring residual impairment likely to affect safe driving.
ACOUSTIC NEUROMA/SCHWANNOMA	Need not notify unless sudden and disabling giddiness.	Need not notify DVLA unless accompanied by disabling giddiness and/or the condition is bilateral.
MALIGNANT TUMOURS (including metastatic deposits) applies to initial occurrence and tumour recurrence/progression.		
Supratentorial		
Grades 1 and II gliomas	1 year off driving, from time of completion of the primary treatment.	Permanent refusal or revocation. (Pineocytoma, grade 1, can be considered on an individual basis 2 years post primary treatment if satisfactory MRI)
WHO Grade III meningioma	2 years off driving from time of completion of primary treatment.	Permanent refusal or revocation.
Grades III and IV gliomas, metastatic deposit(s) and primary CNS lymphomas.	At least 2 years off driving from time of completion of primary treatment.	Permanent refusal or revocation.
Solitary metastatic deposit	If totally excised, can be considered for licensing 1 year after completion of primary treatment if free from recurrence and no evidence of secondary spread elsewhere in the body.	Permanent refusal or revocation.
Infratentorial Tumours		
Grade 1	As for benign tumours: ie. drive on recovery.	Individual assessment.
Grades II, III & IV	As for Supratentorial tumour	Permanent refusal or revocation.
Medulloblastoma or Low Grade Ependymoma	If totally excised, can be considered for licensing 1 year after primary treatment, if free from recurrence.	If entirely infratentorial, can be considered for licensing when disease-free for 5 years after treatment.
High Grade Ependymomas, Other Primary Malignant Brain Tumours and Primary CNS Lymphomas	Normally, a period of 2 years off driving is required following treatment.	Permanent refusal or revocation.
Metastatic deposits	Can be considered 1 year after completion of primary treatment if otherwise well.	Maybe considered 5years from the date of completion of the primary treatment
MALIGNANT INTRACRANIAL TUMOURS IN CHILDREN WHO SURVIVE TO ADULT LIFE WITHOUT RECURRENCE	Normally, a Till 70 licence is issued/maintained.	Individual assessment: see above as for “Benign Supratentorial Tumour”.
When a low grade glioma is an incidental finding and asymptomatic, the case may be considered on an individual basis for Group 1.		

See Appendix at end of this Chapter

NEUROLOGICAL DISORDERS	**GROUP 1 ENTITLEMENT ODL - CAR, M/CYCLE**	**GROUP 2 ENTITLEMENT VOC – LGV/PCV (LORRY/BUS)**	
TRAUMATIC BRAIN INJURY	Usually requires 6-12 months off driving depending on features such as seizures, PTA, dural tear, haematoma and contusions. There will need to have been a satisfactory clinical recovery and in particular no visual field defect, or cognitive impairment likely to affect safe driving. **See also Appendix 1 and 2.**	Refusal or revocation. May be able to return to driving when the risk of seizure has fallen to no greater than 2% per annum, and with no debarring residual impairment likely to affect safe driving.	
SPONTANEOUS ACUTE SUBDURAL HAEMATOMA (treated by craniotomy)	6 months off driving	At least 6 months off driving and shall require an individual assessment	
CHRONIC SUBDURAL (treated surgically)	Resume driving on recovery.	6 months – 1 year off driving, depending on features.	
SUBARACHNOID HAEMORRHAGE 1. NO CAUSE FOUND	Provided comprehensive cerebral angiography normal, may resume driving following recovery. Till 70 licence.	Provided comprehensive cerebral angiography normal, 6 months off driving and may regain licence if no debarring residual impairment likely to affect safe driving.	
2. – (a) **<u>INTRACRANIAL ANEURYSM</u>** N.B.: If any other procedure is undertaken e.g. V.P. shunt, craniotomy for a haematoma etc then the standards for that procedure shall apply.		Modified Rankin Scale (mRS)	
CRANIOTOMY NON MIDDLE CEREBRAL ARTERY ANEURYSM	Drive on clinical recovery	mRS < 2 at 2months 12 months off driving	mRS 2 or > at 2 months 24 months off driving, there should be no residual impairment likely to affect driving.
CRANIOTOMY MIDDLE CEREBRAL ARTERY ANEURYSM	Drive on clinical recovery	mRS < 2 at 2 months 24 months off driving.	mRS 2 or > at 2 months Refusal or Revocation. See* below
ENDOVASCULAR TREATMENT NON MIDDLE CEREBRAL ARTERY ANEURYSM	Drive on clinical recovery	mRS < 2 at 2 months 6 months off driving.	mRS 2 or > at 2 months 24 months off driving, there should be no residual impairment likely to affect driving.
ENDOVASCULAR TREATMENT MIDDLE CEREBRAL ARTERY ANEURYSM	Drive on clinical recovery	mRS < 2 at 2 months 24 months off driving.	mRS 2 or > at 2 months Refusal or Revocation. See* below
* Specialist assessment required, seizure risk should be 2% p.a or less and there should be no residual impairment likely to affect driving.			

See Appendix at end of this Chapter

NEUROSURGICAL DISORDERS	GROUP 1 ENTITLEMENT ODL - CAR, M/CYCLE	GROUP 2 ENTITLEMENT VOC – LGV/PCV (LORRY/BUS)
(b) NO TREATMENT i.e. Aneurysm responsible for SAH but no intervention.	6 months off driving.	Refusal or revocation.
(c) TRULY INCIDENTAL FINDINGS OF INTRACRANIAL ANEURYSM (aneurysm has not been responsible for subarachnoid haemorrhage)		
NO TREATMENT	Drive on clinical recovery.	To be acceptable for licensing, anterior circulation aneurysms (excluding cavernous carotid) must be <13mm in diameter. Posterior circulation aneurysms must be <7mm diameter.
SURGERY CRANIOTOMY	Drive on clinical recovery.	1 year off driving.
ENDOVASCULAR TREATMENT	Drive on clinical recovery.	Cease driving until clinical recovery unless there are complications from the procedure.

See Appendix at end of this Chapter

NEUROLOGICAL DISORDERS	GROUP 1 ENTITLEMENT ODL - CAR, M/CYCLE	GROUP 2 ENTITLEMENT VOC – LGV/PCV (LORRY/BUS)
ARTERIOVENOUS MALFORMATION N.B.: If any other procedure is undertaken e.g. V.P. shunt, craniotomy for a haematoma etc then the standards for that procedure shall apply.		
SUPRATENTORIAL AVMs Intracerebral haemorrhage due to supratentorial AVM:		
a) Craniotomy	6 months off driving; can be re-licensed when there is no debarring residual impairment likely to affect safe driving.	Refusal or revocation until lesion is completely removed or ablated and 10 years seizure-free from last definitive treatment. There must be no debarring residual impairment likely to affect safe driving.
b) Other treatment (embolisation or stereotactic radiotherapy).	1 month off driving; can drive when there is no debarring residual impairment likely to affect safe driving.	As above.
c) No treatment.	As above.	Permanent refusal or revocation.
Incidental finding of a supratentorial AVM (no history of intracranial bleed)		
a) No treatment	Retain	Permanent refusal or revocation.
b) Surgical or other treatment	See above: as for AVM with intracranial haemorrhage.	Refusal or revocation until lesion is completely removed or ablated and 10 years seizure-free from last definitive treatment. There must be no debarring residual impairment likely to affect safe driving.
INFRATENTORIAL AVMs Intracranial haemorrhage due to AVM:		
a) Treated by craniotomy	Can drive when there is no debarring residual impairment likely to affect safe driving.	Refusal/revocation. Non-review licence on confirmation of complete obliteration with no debarring residual impairment likely to affect safe driving.
b) Embolisation/stereotactic radiotherapy	As above.	As above.
c) No treatment.	As above.	Permanent refusal/revocation.

See Appendix at end of this Chapter

NEUROLOGICAL DISORDERS	GROUP 1 ENTITLEMENT ODL - CAR, M/CYCLE	GROUP 2 ENTITLEMENT VOC – LGV/PCV (LORRY/BUS)
Incidental finding of an infratentorial AVM		
a) No treatment	Retain	Individual assessment.
b) Surgical or other treatment	Can drive when there is no debarring residual impairment likely to affect safe driving.	Refusal/revocation. Non-review licence on confirmation of complete obliteration with no debarring residual impairment likely to affect safe driving.
DURAL AV FISTULA	Licence may be issued subject to individual assessment.	Licence may be issued subject to individual assessment.
CAVERNOUS MALFORMATION		
Supratentorial		
a) Incidental	No restriction	No restriction
b) Seizure, no surgical treatment	Epilepsy regulations apply if history of seizure(s).	Epilepsy regulations apply if history of seizure(s).
c) Haemorrhage and/or focal neurological deficit, no surgical treatment	Can drive when there is no debarring residual impairment likely to affect safe driving. Epilepsy regulations apply if history of seizure(s).	Permanently revoke/refuse
d) Treated by surgical excision (craniotomy)	6 months off; can drive when there is no debarring residual impairment likely to affect safe driving Epilepsy regulations apply if history of seizure(s).	Revoked/refuse until 10 years post-obliteration of the lesion and Epilepsy Regulations apply.
e) Treated by radiosurgery irrespective of whether Incidental or symptomatic	No restrictions Epilepsy regulations apply if history of seizure(s).	No restrictions Epilepsy regulations apply if history of seizure(s).
Infratentorial		
a) Incidental	No restriction	No restriction
b) With focal neurological deficit or haemorrhage.	Can drive when there is no debarring residual impairment likely to affect safe driving. Epilepsy regulations apply if history of seizure(s).	Can drive when there is no debarring residual impairment likely to affect safe driving. Epilepsy regulations apply if history of seizure(s).
c) Treated by surgical excision (craniotomy).	As above.	As above.
NB. - Multiple cavernoma: no firm evidence of ↑ morbidity. - Size is not an issue.		

See Appendix at end of this Chapter

NEUROLOGICAL DISORDERS	GROUP 1 ENTITLEMENT ODL - CAR, M/CYCLE	GROUP 2 ENTITLEMENT VOC – LGV/PCV (LORRY/BUS)
INTRACEREBRAL ABSCESS/ SUBDURAL EMPYEMA	One year off driving.	Refusal or revocation. Very high prospective risk of seizure(s). May consider licensing if 10 years seizure-free from treatment.
HYDROCEPHALUS	If uncomplicated, Till 70 licence retained	Can be issued with a licence if uncomplicated and no associated neurological problems.
INTRAVENTRICULAR SHUNT OR EXTRAVENTRICULAR DRAIN Insertion or revision of upper end of ventricular shunt or extra-ventricular drain.	6 months off . Can then be re-licensed when there is no debarring residual impairment likely to affect safe driving.	Minimum 6 months off and then licensing shall be dependent upon the individual assessment of the underlying condition.
NEUROENDOSCOPIC PROCEDURES, eg. III rd ventriculostomy	6 months off. Can then be re-licensed when there is no debarring residual impairment likely to affect safe driving and no other disqualifying condition.	Minimum 6 months off and then licensing shall be dependent upon the individual assessment of the underlying condition.
INTRACRANIAL PRESSURE - MONITORING DEVICE Inserted by Burr hole surgery.	The prospective risk from the underlying condition must be considered.	The prospective risk from the underlying condition must be considered.
IMPLANTED ELECTRODES: DEEP BRAIN STIMULATION FOR MOVEMENT DISORDER OR PAIN	If no complications from surgery and seizure free, can drive when there is no debarring residual impairment likely to affect safe driving.	If no complications from surgery, seizure free and underlying condition non-progressive, fitness to drive can when there is no debarring residual impairment likely to affect safe driving.
IMPLANTED MOTOR CORTEX STIMULATOR FOR PAIN RELIEF	If aetiology of pain is non-cerebral e.g. trigeminal neuralgia, 6 months off. If the aetiology is cerebral e.g. stroke, 12 month off. Can then drive when there is no debarring residual impairment likely to affect safe driving.	Refusal or Revocation.

See Appendix at end of this Chapter

APPENDIX

THE CURRENT EPILEPSY REGULATIONS FOR GROUP 1 AND GROUP 2 ENTITLEMENT

GROUP 1

"(2) Epilepsy is prescribed for the purposes of section 92(2) of the Traffic Act as a relevant disability in relation to an applicant for, or a holder of, a Group 1 licence, who has had two or more epileptic seizures during the previous five year period.

(2A) Epilepsy is prescribed for the purposes of section 92(4)(b) of the Traffic Act in relation to an applicant for a Group 1 licence who satisfies the conditions set out in paragraph (2F) and who has either—

(a) been free from any unprovoked seizure during the period of one year immediately preceding the date when the licence is granted; or

(b) during that one year period has suffered no unprovoked seizure other than a permitted seizure.

(2B) A permitted seizure for the purposes of paragraph (2A)(b) is—

(a) a seizure, which can include a medication adjustment seizure, falling within only one of the permitted patterns of seizure; or

(b) a medication adjustment seizure where—

(i) that medication adjustment seizure does not fall within a permitted pattern of seizure;

(ii) previously effective medication has been reinstated for at least 6 months immediately preceding the date when the licence is granted;

(iii) that seizure occurred more than 6 months before the date when the licence is granted; and

(iv) there have been no other unprovoked seizures since that seizure; or

(c) a seizure occurring before a medication adjustment seizure permitted under sub-paragraph (b), where—

(i) that earlier seizure had, to that point, formed part of only one permitted pattern of seizure and had occurred prior to any medication adjustment seizure not falling within the same permitted pattern; or

(ii) it is a medication adjustment seizure, which was not followed by any other type of unprovoked seizure, except for another medication adjustment seizure.

(2C) A permitted pattern of seizure for the purposes of paragraph (2B), is a pattern of seizures—

(a) occurring during sleep, where—

(i) there has been a seizure while asleep more than one year before the date when the licence is granted;

(ii) there have been seizures only while asleep between the date of that seizure while asleep and the date the licence is granted; and

(iii) there has never been an unprovoked seizure while awake; or

(b) occurring during sleep, where—

(i) there has been a seizure while asleep more than three years before the date when the licence is granted;

(ii) there have been seizures only while asleep between the date of that seizure while asleep and the date the licence is granted; and

(iii) there is also a history of unprovoked seizure while awake, the last of which occurred more than three years before the date when the licence is granted, or

(c) without influence on consciousness or the ability to act, where—

(i) such a seizure has occurred more than one year before the date when the licence is granted;

(ii) there have only been such seizures between the date of that seizure and the date when the licence is granted; and

(iii) there has never been any other type of unprovoked seizure.

(2D) An isolated seizure is prescribed for the purposes of section 92(2) of the Traffic Act as a relevant disability in relation to an applicant for, or a holder of, a Group 1 licence—

(a) in a case where there is an underlying causative factor that may increase future risk, where such a seizure has occurred during the previous one year period; and

(b) in any other case, where such a seizure has occurred during the previous 6 month period.

(2E) An isolated seizure is prescribed for the purposes of section 92(4)(b) of the Traffic Act in relation to an applicant for a Group 1 licence, who—

(a) (i) in a case where there is an underlying causative factor that may increase future risk, has had such a seizure more than one year immediately before the date when the licence is granted; and

(ii) in any other case, has had such a seizure more than 6 months immediately before the date when the licence is granted;

(b) has had no other unprovoked seizure since that seizure; and

(c) satisfies the conditions set out in paragraph (2F).

(2F) The conditions are that—

(a) so far as is practicable, the applicant complies with the directions regarding treatment for epilepsy or isolated seizure, including directions as to regular medical check-ups made as part of that treatment, which may from time to time be given by a registered medical practitioner or one of the clinical team working under the supervision of that registered medical practitioner;

(b) if required to do so by the Secretary of State, the applicant has provided a signed declaration agreeing to observe the condition in sub-paragraph (a);

(c) if required by the Secretary of State, there has been an appropriate medical assessment by a registered medical practitioner; and

(d) the Secretary of State is satisfied that the driving of a vehicle by the applicant in accordance with the licence is not likely to be a source of danger to the public.”.

GROUP 2

“(8) Epilepsy is prescribed for the purposes of section 92(2) of the Traffic Act as a relevant disability in relation to an applicant for, or a holder of, a Group 2 licence, where two or more epileptic seizures have occurred, or that person has been prescribed medication to treat epilepsy, during the previous ten year period.

(8A) Epilepsy is prescribed for the purposes of section 92(4)(b) of the Traffic Act in relation to an applicant for a Group 2 licence who—

(a) in the case of a person whose last epileptic seizure was an isolated seizure, satisfies the conditions in paragraph (8C) and (8D); or

(b) in any other case, satisfies the conditions set out in paragraph (8D) and who, for a period of at least 10 years immediately preceding the date when the licence is granted has—

(i) been free from any epileptic seizure, and

(ii) has not been prescribed any medication to treat epilepsy.

(8B) An isolated seizure is prescribed for the purposes of section 92(2) of the Traffic Act as a relevant disability, in relation to an applicant for, or a holder of, a Group 2 licence, where during the previous five year period, such a seizure has occurred, or that person has been prescribed medication to treat epilepsy or a seizure.

(8C) An isolated seizure is prescribed for the purposes of section 92(4)(b) of the Traffic Act in relation to an applicant for a Group 2 licence who satisfies the conditions set out in paragraph (8D) and who, for a period of at least five years immediately preceding the date when the licence is granted—

(a) has been free from any unprovoked seizure, and

(b) has not been prescribed medication to treat epilepsy or a seizure.

(8D) The conditions are that—

(a) if required by the Secretary of State, there has been an appropriate medical assessment by a neurologist; and

(b) the Secretary of State is satisfied that the driving of a vehicle by the applicant, in accordance with the licence, is not likely to be a source of danger to the public.”.

GUIDANCE FOR WITHDRAWAL OF ANTI-EPILEPSY MEDICATION BEING WITHDRAWN ON SPECIFIC MEDICAL ADVICE
(N.B. This advice only relates to treatment for epilepsy)

From a medico-legal point of view, the risk of further epileptic seizures occurring during this therapeutic procedure should be noted. If an epileptic seizure does occur, the patient will need to satisfy driving licence regulations before resuming driving and will need to be counselled accordingly.

It is clearly recognised that withdrawal of anti-epilepsy medication is associated with a risk of seizure recurrence. A number of studies have shown this, including the randomised study of anti-epilepsy drug withdrawal in patients in remission, conducted by the Medical Research Council Anti-epileptic Drug Withdrawal Study Group. This study shows a 40% increased associated risk of seizure in the first year of withdrawal of medication compared with those who continued on treatment.

The Secretary of State's Honorary Medical Advisory Panel on Driving and Disorders of the Nervous System has recommended that patients should be warned of the risk they run, both of losing their driving licence and also of having a seizure which could result in a road traffic accident. The Panel advises that patients should be advised **not** to drive from commencement of the period of withdrawal and thereafter for a period of 6 months after cessation of treatment. The Panel considers that a person remains as much at risk of seizure associated with drug withdrawal during the period of withdrawal as in the 6 months after withdrawal.

This advice may not be appropriate in every case. One specific example is withdrawal of anticonvulsant medication when there is a well-established history of seizures only while asleep. In such cases, any restriction in driving is best determined by the physicians concerned, after considering the history. It is up to the patient to comply with such advice.

It is important to remember that the epilepsy regulations are still relevant even if epileptic seizures occur after medication is omitted, for example on admission to hospital for any condition.

PROVOKED SEIZURES:

For Group 1 and possibly Group 2 drivers or applicants, provoked or acute symptomatic seizures may be dealt with on an individual basis by DVLA if there is no previous seizure history. **Seizures associated with alcohol or drug misuse, sleep deprivation or a structural abnormality are not considered provoked for licensing purposes. Similarly, reports of seizures as a side-effect of prescribed medication do not automatically imply that such events will be considered as provoked**. For seizure(s) with alcohol or illicit drugs, please see relevant section in the booklet.

Doctors may wish to advise patients that the period of time likely to be recommended off driving will be influenced inter alia, by:-

a) whether it is clear that the seizure had been provoked by a stimulus which does not convey any risk of recurrence and does not represent an unmasking of an underlying liability; and,

b) whether the stimulus had been successfully/appropriately treated or is unlikely to occur at the wheel.

In the absence of any previous seizure history or previous cerebral pathology, the following seizures may also be treated as provoked:

- eclamptic seizures
- reflex anoxic seizures
- an immediate seizure (within seconds) at the time of a head injury
- seizure in first week following a head injury (see head injury section). at the time of a stroke/TIA or within the ensuing 24 hours
- during intracranial surgery or in the ensuing 24 hours.

Seizures occurring during an acute exacerbation of multiple sclerosis or migraine will be assessed on an individual basis by DVLA.

CHAPTER 2

CARDIOVASCULAR DISORDER

NB A Left Ventricular Ejection Fraction of < 0.4 is considered a bar to Group 2 Entitlement.

CARDIOVASCULAR DISORDER	GROUP 1 ENTITLEMENT ODL – CAR, M/CYCLE	GROUP 2 ENTITLEMENT VOC – LGV/PCV (LORRY/BUS)
ANGINA	**Driving must cease when symptoms occur at rest, with emotion or at the wheel.** Driving may recommence when satisfactory symptom control is achieved. **DVLA need not be notified.**	**Refusal or revocation with continuing symptoms (treated and/or untreated)** Re-licensing may be permitted thereafter provided: • Free from angina for at least 6/52 • The exercise or other functional test requirements can be met • There is no other disqualifying condition.
ACUTE CORONARY SYNDROMES (ACS) defined as: 1. Unstable angina (symptoms at rest with ECG changes) 2. Non STEMI with at least two of the following criteria • Symptoms at rest • Raised serum Troponin • ECG changes 3. STEMI symptoms with ST elevation on ECG	If **successfully** treated by coronary angioplasty, driving may recommence after 1/52 provided: • No other URGENT revascularisation is planned. (URGENT refers to within 4/52 from acute event) • LVEF is at least 40% prior to hospital discharge. • There is no other disqualifying condition. If not successfully treated by coronary angioplasty, driving may recommence after 4/52 provided: • There is no other disqualifying condition. **DVLA need not be notified**.	All Acute Coronary Syndromes disqualify the licence holder from driving for at least 6/52. Re/licensing may be permitted thereafter provided: • The exercise or other functional test requirements can be met. • There is no other disqualifying condition.
PERCUTANEOUS CORONARY INTERVENTION (Angioplasty ± stent) **elective**	**Driving must cease for at least 1/52.** Driving may recommence thereafter provided there is no other disqualifying condition. **DVLA need not be notified.**	**Disqualifies from driving for at least 6/52.** Re/licensing may be permitted thereafter provided: • The exercise or other functional test requirements can be met • There is no other disqualifying condition.
CABG	**Driving must cease for at least 4/52.** Driving may recommence thereafter provided there is no other disqualifying condition. **DVLA need not be notified.**	**Disqualifies from driving for at least 3/12**. Re/licensing may be permitted thereafter provided: • There is no evidence of significant impairment of left ventricular function i.e. LVEF is = to or > 40%. • The exercise or other functional test requirements can be met 3 months or more post operatively. • There is no other disqualifying condition.

See Appendix at end of this Chapter

NB A Left Ventricular Ejection Fraction of < 0.4 is considered a bar to Group 2 Entitlement.

CARDIOVASCULAR DISORDER	**GROUP 1 ENTITLEMENT** **ODL – CAR, M/CYCLE**	**GROUP 2 ENTITLEMENT** **VOC – LGV/PCV (LORRY/BUS)**
ARRHYTHMIA Sinoatrial disease Significant atrio-ventricular conduction defect Atrial flutter/fibrillation Narrow or broad complex tachycardia (See also following Sections - Pacemakers are considered separately) **NB: Transient Arrhythmias** occurring during acute coronary syndromes do not require assessment under this Section.	**Driving must cease if the arrhythmia has caused or is likely to cause incapacity.** Driving may be permitted when underlying cause has been identified and **controlled** for at least 4/52. **DVLA need not be notified unless there are distracting/disabling symptoms.**	**Disqualifies from driving if the arrhythmia has caused or is likely to cause incapacity.** Driving may be permitted when: • The arrhythmia is controlled for at least 3/12. • The LV ejection fraction is = to or > 0.4. • There is no other disqualifying condition.
SUCCESSFUL CATHETER ABLATION	**Driving must cease for at least 2/7.** Driving may be permitted thereafter provided there is no other disqualifying condition. **DVLA need not be notified.**	Following **successful** catheter ablation for an arrhythmia that has caused or would likely have caused incapacity, driving should cease for 6/52. Driving may recommence thereafter provided there is no other disqualifying condition. When the arrhythmia has **not** caused nor would likely have caused incapacity, driving may recommence after 2/52 provided there is no other disqualifying condition.
PACEMAKER IMPLANT Includes box change	**Driving must cease for at least 1/52.** Driving may be permitted thereafter provided there is no other disqualifying condition.	**Disqualifies from driving for 6/52.** Re/licensing may be permitted thereafter provided there is no other disqualifying condition.
UNPACED CONGENITAL COMPLETE HEART BLOCK	May drive if asymptomatic.	Bars whether symptomatic or asymptomatic.
ATRIAL DEFIBRILLATOR Physician/patient activated	Driving may continue provided there is no other disqualifying condition.	Re/licensing may be permitted provided • The arrhythmia requirements are met. • There is no other disqualifying condition.
ATRIAL DEFIBRILLATOR Automatic	Driving may continue provided there is no other disqualifying condition. See also ICD Section	**Permanently bars**

See Appendix at end of this Chapter

NB A Left Ventricular Ejection Fraction of < 0.4 is considered a bar to Group 2 Entitlement.

CARDIOVASCULAR DISORDER	GROUP 1 ENTITLEMENT ODL – CAR, M/CYCLE	GROUP 2 ENTITLEMENT VOC – LGV/PCV (LORRY/BUS)
IMPLANTABLE CARDIOVERTER DEFIBRILLATOR (ICD) implanted for ventricular arrhythmia **associated with incapacity**	Patients with ICDs implanted for sustained ventricular arrhythmias should not drive for: 1) A period of 6/12 after the first implant 2) A further 6/12 after any shock therapy and/or symptomatic antitachycardia pacing (see 3a below). 3a) A period of 2 years if any therapy following device implantation has been accompanied by incapacity (whether caused by the device or arrhythmia), **except as in 3b and 3c** 3b) If therapy was delivered due to an inappropriate cause, i.e. atrial fibrillation or programming issues, then driving may resume 1/12 after this has been completely controlled to the satisfaction of the cardiologist. **DVLA need not be notified.** 3c) If the incapacitating shock was appropriate (i.e. for sustained VT or VF) and steps have been taken to prevent recurrence, (e.g.introduction of anti-arrhythmic drugs or ablation procedure) driving may resume after 6/12 **in the absence of further symptomatic therapy.** **For 2 and 3a/3c, if the patient has been re-licensed prior to the event, DVLA should be notified.** 4) A period of 1/12 off driving must occur following any revision of the electrodes or alteration of anti-arrhythmic drug treatment. 5) A period of 1/52 off driving is required after a defibrillator box change. **Resumption of driving requires that;** 1) The device is subject to regular review with interrogation. 2) There is no other disqualifying condition.	**Permanently bars**

See Appendix at end of this Chapter

NB A Left Ventricular Ejection Fraction of < 0.4 is considered a bar to Group 2 Entitlement.

CARDIOVASCULAR DISORDER	GROUP 1 ENTITLEMENT ODL – CAR, M/CYCLE	GROUP 2 ENTITLEMENT VOC – LGV/PCV (LORRY/BUS)
IMPLANTABLE CARDIOVERTER DEFIBRILLATOR (ICD) implanted for sustained ventricular arrhythmia which did **not** cause incapacity	If the patient presents with a non-disqualifying cardiac event, i.e. haemodynamically stable non-incapacitating sustained ventricular tachycardia, the patient can drive 1/12 after ICD implantation providing all of the following conditions are met: • LVEF > than 35% • No fast VT induced on electrophysiological study (RR< 250 msec) • Any induced VT could be pace-terminated by the ICD twice, without acceleration, during the post implantation study. **DVLA need not be notified.** Should the ICD subsequently deliver ATP and/or shock therapy (except during normal clinical testing) then the licensing criteria on the previous page applies and **DVLA should be notified.**	**Permanently bars**
PROPHYLACTIC ICD IMPLANT	Asymptomatic individuals with high risk of significant arrhythmia. Driving should cease for 1/12. **DVLA need not be notified.** Should the ICD subsequently deliver ATP and/or shock therapy (except during normal clinical testing) then the licensing criteria on the previous page applies and **DVLA should be notified.**	**Permanently bars**
ASCENDING/DESCENDING THORACIC and ABDOMINAL AORTIC ANEURYSM	**DVLA should be notified** of any aneurysm of **6 cm** in diameter, despite treatment. Licensing will be permitted subject to **annual review**. Driving may continue after **satisfactory** medical (blood pressure control) or surgical treatment, without evidence of further enlargement. There should be no other disqualifying condition. **An aortic diameter of 6.5 cm or more disqualifies from driving.**	Disqualifies from driving if the aortic diameter is **> 5.5cm**. Driving may continue after **satisfactory** medical or surgical treatment, unless other disqualifying condition. **NB: The Exercise or other functional test requirements will apply to abdominal aortic aneurysm**

See Appendix at end of this Chapter

NB A Left Ventricular Ejection Fraction of < 0.4 is considered a bar to Group 2 Entitlement.

CARDIOVASCULAR DISORDER	GROUP 1 ENTITLEMENT ODL – CAR, M/CYCLE	GROUP 2 ENTITLEMENT VOC – LGV/PCV (LORRY/BUS)
CHRONIC AORTIC DISSECTION	Driving may continue after **satisfactory** medical (blood pressure control) or surgical treatment, unless other disqualifying condition. **DVLA need not be notified**	Re/licensing may be permitted if ALL of the following criteria can be met: • The maximum transverse diameter of the aorta, including false lumen/thrombosed segment, does not exceed **5.5cm** • There is complete thrombosis of the false lumen • The BP is well controlled* NOTE "well controlled" refers to clinical, NOT DVLA licensing standard.
MARFAN'S SYNDROME	DVLA need not be notified unless there is aneurysm.	Re/licensing permitted subject to: • The requirements for aortic aneurysm are met • Satisfactory medical treatment • Annual cardiac review to include aortic root measurement **NB: Aortic root replacement will debar.**
CAROTID ARTERY STENOSIS (see also neurological section)	**DVLA need not be notified**	If the level of stenosis is severe enough to warrant intervention, the exercise or other functional test requirements must be met.
PERIPHERAL ARTERIAL DISEASE	Driving may continue provided there is no other disqualifying condition. **DVLA need not be notified**	Re/licensing may be permitted provided: • There is no symptomatic myocardial ischaemia • The exercise or other functional requirements can be met
HYPERTENSION	Driving may continue **unless** treatment causes unacceptable side effects. **DVLA need not be notified**	**Disqualifies from driving if resting BP consistently 180 mm Hg systolic or more and/or 100 mm Hg diastolic or more.** Re/licensing may be permitted when controlled provided that treatment does not cause side effects which may interfere with driving.

See Appendix at end of this Chapter

NB A Left Ventricular Ejection Fraction of < 0.4 is considered a bar to Group 2 Entitlement.

CARDIOVASCULAR DISORDER	**GROUP 1 ENTITLEMENT** **ODL – CAR, M/CYCLE**	**GROUP 2 ENTITLEMENT** **VOC – LGV/PCV (LORRY/BUS)**
HYPERTROPHIC CARDIOMYOPATHY (H.C.M) (See also arrhythmia, pacemaker and ICD sections)	Driving may continue provided no other disqualifying condition. **DVLA need not be notified**	Disqualifies from driving if symptomatic. Re/Licensing may only be permitted when at least 3 of the following criteria are met: • There is no family history in a first degree relative of sudden premature death from presumed HCM. • The cardiologist can confirm that the HCM is not anatomically severe. The maximum wall thickness does not exceed **3cm**. • There is no serious abnormality of heart rhythm demonstrated; e.g. ventricular tachy-arrhythmia excluding isolated ventricular pre excitation beats. • There is at least a 25mm Hg increase in systolic blood pressure during exercise testing - (exercise testing to be repeated every 3 years). **See** Appendix **to this Chapter for full details.**
DILATED CARDIOMYOPATHY (See also arrhythmia, pacemaker, I.C.D and heart failure sections etc)	Driving may continue provided no other disqualifying condition. **DVLA need not be notified**	**Disqualifies from driving if symptomatic.** Re/licensing may be permitted provided that there is no other disqualifying condition.
ARRHYTHMOGENIC RIGHT VENTRICULAR CARDIOMYOPATHY (ARVC) AND ALLIED DISORDERS (**See also arrhythmia, pacemaker and ICD sections**)	**Asymptomatic** – Driving may continue. **DVLA need not be notified.** **Symptomatic** – Driving must cease if an arrhythmia has caused or is likely to cause incapacity. Re/licensing may be permitted when arrhythmia is controlled and there is no other disqualifying condition.	**Asymptomatic** – Driving must cease but may be permitted following Specialist electrophysiological assessment provided there is no other disqualifying condition. **Symptomatic** – permanently bars
HEART FAILURE	Driving may continue provided there are no symptoms that may distract the driver's attention. **DVLA need not be notified**	**Disqualifies from driving if symptomatic.** Re/licensing may be permitted provided: • The LV ejection fraction is = to or > 0.4. • There is no other disqualifying condition Exercise or other functional testing may be required depending on the likely cause for the heart failure.

See Appendix at end of this Chapter

NB A Left Ventricular Ejection Fraction of < 0.4 is considered a bar to Group 2 Entitlement.

CARDIOVASCULAR DISORDER	**GROUP 1 ENTITLEMENT** **ODL – CAR, M/CYCLE**	**GROUP 2 ENTITLEMENT** **VOC – LGV/PCV (LORRY/BUS)**
LEFT VENTRICULAR ASSIST DEVICES	**Driving should cease on insertion.** (Re-) licensing can be considered on an individual basis 6/12 after device implantation. **DVLA should be notified**.	**Permanently bars**
CARDIAC RESYNCHRONISATION THERAPY (CRT) CRT-P	**Driving must cease for at least 1/52 following implantation.** Driving may continue provided There are no symptoms relevant to driving. There is no other disqualifying condition.	**Disqualifies from driving for 6/52 Following Implantation.** Re/licensing may be permitted provided: • The Heart Failure requirements are met. • There is no other disqualifying condition.
CRT-D	Driving may be permitted provided The ICD requirements are met. There is no other disqualifying condition.	**Permanently bars**
HEART OR HEART/LUNG TRANSPLANT	Driving may continue provided no other disqualifying condition. **DVLA need not be notified**	**Disqualifies from driving if symptomatic.** Re/licensing may be permitted provided: • The exercise or other functional test requirements can be met. • The LV ejection fraction is = to or > 0.4. • There is no other disqualifying condition.
HEART VALVE DISEASE (to include surgery, ie replacement and/or repair)	Driving may continue provided no other disqualifying condition. **DVLA need not be notified**	**Disqualifies from driving:** • Whilst symptomatic. • For 12 months after cerebral embolism following which Specialist assessment is required to determine licensing fitness. Re/licensing may be permitted provided that there is no other disqualifying condition.

See Appendix at end of this Chapter

NB A Left Ventricular Ejection Fraction of < 0.4 is considered a bar to Group 2 Entitlement.

CARDIOVASCULAR DISORDER	**GROUP 1 ENTITLEMENT** **ODL – CAR, M/CYCLE**	**GROUP 2 ENTITLEMENT** **VOC – LGV/PCV (LORRY/BUS)**
CONGENITAL HEART DISEASE	Driving may continue provided there is no other disqualifying condition. Following a first licence application or identification of such a condition, specialist assessment may be required before a licence is (re)issued. Certain conditions will require the issue of a medical review licence for 1, 2 or 3 years.	**Disqualifies from driving when complex or severe disorder(s) is (are) present.** Following a first licence application or identification of such a condition, specialist assessment may be required before a licence is (re)issued. Those with minor disease and others who have had successful repair of defects or relief of valvular problems, fistulae etc may be licensed provided there is no other disqualifying condition. Certain conditions will require the issue of a medical review licence for 1, 2 or 3 years.
SYNCOPE **NB Cough Syncope** **see Chapter 7**	See section entitled **"Loss of Consciousness"** (Chapter 1)	See section entitled **"Loss of Consciousness"** (Chapter 1)
ECG ABNORMALITY Suspected myocardial infarction	Driving may continue unless other disqualifying condition **DVLA need not be notified**	Re/licensing may be permitted provided: • There is no other disqualifying condition. • The exercise or other functional test requirements can be met
LEFT BUNDLE BRANCH BLOCK	Driving may continue unless other disqualifying condition **DVLA need not be notified**	Re/licensing may be permitted provided: • There is no other disqualifying condition. • The Myocardial Perfusion Scan or Stress Echocardiography requirements can be met.
PRE-EXCITATION	Driving may continue unless other disqualifying condition. **DVLA need not be notified**	May be ignored **unless** associated with an arrhythmia (See Arrhythmia Section) or other disqualifying condition.

See Appendix at end of this Chapter

APPENDIX

GROUP 1 AND 2 ENTITLEMENTS

MEDICATION

If drug treatment for any cardiovascular condition is required, any adverse effect which is likely to affect driver performance will disqualify.

GROUP 2 ENTITLEMENT ONLY

LICENCE DURATION

An applicant or driver who has, after cardiac assessment, (usually for ischaemic or untreated heart valve disease) been permitted to hold either a LGV or PCV licence will usually be issued with a short term licence (maximum duration 3 years) renewable on receipt of satisfactory medical reports.

EXERCISE TESTING

Exercise evaluation shall be performed on a bicycle* or treadmill. Drivers should be able to complete 3 stages of the standard Bruce protocol or equivalent safely, without anti-anginal** medication for 48 hours and should remain free from signs of cardiovascular dysfunction, viz. angina pectoris, syncope, hypotension, sustained ventricular tachycardia, and/or electrocardiographic ST segment shift which accredited medical opinion interprets as being indicative of myocardial ischaemia (usually >2mm horizontal or down-sloping) during exercise or the recovery period. In the presence of established coronary heart disease, exercise evaluation shall be required at regular intervals not to exceed 3 years.

* cycling for ten minutes with 20 watt increments/minute to a total of 200W

** Anti-anginal medication refers to the use of Nitrates, B-blockers, Calcium channel blockers, Nicorandil, Ivabradine and Ranolazine **prescribed for anti-anginal purposes or for other reasons e.g. cardio-protection**.

NB: When any of the above drugs are being prescribed purely for the control of hypertension or an arrhythmia then discontinuation prior to exercise testing is not required.

Should Atrial Fibrillation develop de novo during Exercise testing, provided the individual meets all the DVLA Exercise tolerance test criteria, the individual will be required to undergo an Echocardiogram and meet the licensing criteria, just as any individual with a pre-existing Atrial Fibrillation.

CHEST PAIN OF UNCERTAIN CAUSE

Exercise testing should be carried out as above. Those with a locomotor disability who cannot comply will require either a gated Myocardial Perfusion Scan, Stress Echo study and/or specialised cardiological opinion.

STRESS MYOCARDIAL PERFUSION SCAN/STRESS ECHOCARDIOGRAPHY

The licensing standard requires that:

1. The LVEF is 40% or more.
2. (a) No more than 10% of the Myocardium is affected by reversible ischaemic change on Myocardial Perfusion Imaging.

   OR

   (b) No more than one segment is affected by reversible ischaemic change on Stress Echocardiography.

NB: Full details of DVLA protocol requirements for such tests can be obtained on request.

CORONARY ANGIOGRAPHY

The functional implication of coronary heart disease is considered to be more predictive for licensing purposes than the anatomical findings. For this reason the Exercise Tolerance Test and where necessary, Myocardial Perfusion Imaging or Stress Echocardiography are the investigations of relevance for licensing purposes and it is the normal requirement that the standard of one or other of these must be met. Angiography is therefore not commissioned for (re-) licensing purposes. When there remains conflict between the outcome of a functional test and the results of recent angiography, such cases can be considered on an individual basis. However, (re-) licensing will not normally be considered unless the coronary arteries are **unobstructed or the stenosis is not flow limiting** and the **left ventricular ejection fraction is = to or > 40%**.

'Predictive' refers to the risk of an infarct within 1 year. Grafts are considered as 'Coronary Arteries'.

ETT and HYPERTROPHIC CARDIOMYOPATHY

For the purpose of assessment of Hypertrophic Cardiomyopathy cases, an Exercise Test falling short of 9 minutes would be acceptable provided:

1. There is no obvious cardiac cause for stopping the test in less than 9 minutes and
2. There is at least a 25mm Hg rise in Systolic blood pressure during exercise testing
3. Meets all other requirements as mentioned in HCM section.

CHAPTER 3

DIABETES MELLITUS

DIABETES MELLITUS	GROUP 1 ENTITLEMENT ODL - CAR, M/CYCLE	GROUP 2 ENTITLEMENT VOC – LGV/PCV (LORRY/BUS)
INSULIN-TREATED Drivers are sent a detailed letter of explanation about their licence and driving by DVLA. **See Appendix to this Chapter for** a sample of this letter (DIABINF)	• Must have awareness of hypoglycaemia. • Must not have had more than one episode of hypoglycaemia requiring the assistance of another person in the preceding twelve months. • There must be appropriate blood glucose monitoring. This has been defined by the Secretary of State's Honorary Medical Advisory Panel on Driving and Diabetes as no more than 30 minutes before the start of the first journey and every 2 hours while driving. • Must not be regarded as a likely source of danger to the public while driving. • The visual standards for acuity and visual field must be met Impaired awareness of hypoglycaemia has been defined by the Secretary of State's Honorary Medical Advisory Panel on Driving and Diabetes as, 'an inability to detect the onset of hypoglycaemia because of a total absence of warning symptoms'. If meets the medical standard a 1, 2 or 3 year licence will be issued.	May apply for any Group 2 licence. Must satisfy the following criteria : • No episode of hypoglycaemia requiring the assistance of another person has occurred in the preceding 12 months. • Has full awareness of hypoglycaemia. • Regularly monitors blood glucose at least twice daily and at times relevant to driving, (no more than 2 hours before the start of the first journey and every 2 hours while driving), using a glucose meter with a memory function to measure and record blood glucose levels. At the annual examination by an independent Consultant Diabetologist, 3 months of blood glucose readings must be available. • Must demonstrate an understanding of the risks of hypoglycaemia. There are no other debarring complications of diabetes such as a visual field defect. If meets the medical standards a 1 year licence will be issued.
TEMPORARY INSULIN TREATMENT e.g. gestational diabetes, post-myocardial infarction, participants in oral/inhaled insulin trials.	Provided they are under medical supervision and have not been advised by their doctor that they are at risk of disabling hypoglycaemia, need not notify DVLA. If experiencing disabling hypoglycaemia, DVLA should be notified. Notify DVLA if treatment continues for more than 3 months or for more than 3 months after delivery for gestational diabetes.	As above

See Appendix at end of this Chapter

DIABETES MELLITUS	**GROUP 1 ENTITLEMENT** **ODL - CAR, M/CYCLE**	**GROUP 2 ENTITLEMENT** **VOC – LGV/PCV (LORRY/BUS)**
MANAGED BY TABLETS WHICH CARRY A RISK OF INDUCING HYPOGLYCAEMIA. THIS INCLUDES SULPHONYLUREAS AND GLINIDES **See Appendix to this Chapter for** INF188/2	Must not have had more than one episode of hypoglycaemia requiring the assistance of another person within the preceding 12 months. It may be appropriate to monitor blood glucose regularly and at times relevant to driving to enable the detection of hypoglycaemia. Must be under regular medical review. If the above requirements and all of those set out in the attached information on INF188/2 are met, DVLA does not require notification. This information leaflet can be printed and retained for future reference. Alternatively, if the information indicates that medical enquiries will need to be undertaken, DVLA should be notified.	Must satisfy the following criteria: • No episode of hypoglycaemia requiring the assistance of another person has occurred in the preceding 12 months. • Has full awareness of hypoglycaemia. • Regularly monitors blood glucose at least twice daily and at times relevant to driving. • Must demonstrate an understanding of the risks of hypoglycaemia. • There are no other debarring complications of diabetes such as a visual field defect. If meets the medical standards 1, 2 or 3 year licence will be issued.
MANAGED BY TABLETS OTHER THAN THOSE ABOVE OR BY NON-INSULIN INJECTABLE MEDICATION **See Appendix to this Chapter for** INF188/2	If all the requirements set out in the attached information on INF188/2 are met, and they are under regular medical review, DVLA does not require notification. This information leaflet can be printed and retained for future reference. Alternatively, if the information indicates that medical enquiries will need to be undertaken, DVLA should be notified.	Drivers will be licensed unless they develop relevant disabilities e.g. diabetic eye problem affecting visual acuity or visual fields, in which case either refusal, revocation or short period licence.
MANAGED BY DIET ALONE	Need not notify DVLA unless develop relevant disabilities e.g. Diabetic eye problems affecting visual acuity or visual field or if insulin required.	Need not notify DVLA unless develop relevant disabilities e.g. Diabetic eye problems affecting visual acuity or visual field or if insulin required.
Impaired awareness of Hypoglycaemia	If confirmed, driving must stop. Driving may resume provided reports show awareness of hypoglycaemia has been regained, confirmed by consultant/GP report.	See previous page for **insulin treated**. Refusal or revocation.
Eyesight complications (affecting visual acuity or fields)	See Section: **Visual Disorders**	See previous page for **insulin treated** and Section: **Visual Disorders**.
Renal Disorders	See Section: **Renal Disorders**	See Section: **Renal Disorders**
Limb Disability e.g. peripheral neuropathy	See Section: **Disabled Drivers** at **Appendix 1.**	As Group I

See Appendix at end of this Chapter

APPENDIX

- **Police, Ambulance and Health Service Vehicle Driver Licensing***

The Secretary of State's Honorary Medical Advisory Panel on Diabetes and Driving has recommended that drivers with insulin treated diabetes should not drive emergency vehicles. This takes account of the difficulties for an individual, regardless of whether they may appear to have exemplary glycaemic control, in adhering to the monitoring processes required when responding to an emergency situation.

*Caveat: The advice of the Panels on the interpretation of EC and UK legislation, and its appropriate application, is made within the context of driver licensing and the DVLA process. It is for others to decide whether or how those recommendations should be interpreted for their own areas of interest, in the knowledge of their specific circumstances.

A Guide for Drivers with Insulin Treated Diabetes who wish to apply for Group 2 (LGV/PCV) Entitlement

Qualifying Conditions which must be met

- No episode of hypoglycaemia requiring the assistance of another person has occurred in the preceding 12 months.
- Must have full awareness of hypoglycaemia.
- Must demonstrate an understanding of the risks of hypoglycaemia.
- Will not be able to apply until their condition has been stable for a period of at least one month.
- Must regularly monitor their condition by checking their blood glucose levels at least twice daily and at times relevant to driving. A glucose meter with a memory function to measure and record blood glucose levels must be used.
- DVLA will arrange an examination by an independent hospital consultant who specialises in the treatment of diabetes every 12 months. At the examination, the consultant will require sight of their blood glucose records for the previous 3 months.
- Must have no other condition which would render them a danger when driving Group 2 vehicles.
- They will be required to sign an undertaking to comply with the directions of doctors(s) treating the diabetes and to report immediately to DVLA any significant change in their condition.

Information for drivers with Diabetes treated by non-insulin medication, diet or both

Please keep this leaflet safe so you can refer to it in the future.

Drivers do not need to tell DVLA if their diabetes is treated by tablets, diet or both and they are free of the complications listed below.

Some people with diabetes develop associated problems that may affect their driving.

Hypoglycaemia (low blood sugar)
Hypoglycaemia (also known as a hypo) is the medical term for a low blood glucose (sugar) level.

Severe hypoglycaemia means the assistance of another person is required
The risk of hypoglycaemia is the main danger to safe driving and can occur with diabetes treated with insulin or tablets or both. This may endanger your own life as well as that of other road users. Many of the accidents caused by hypoglycaemia are because drivers carry on driving even though they get warning symptoms of hypoglycaemia. If you get warning symptoms of hypoglycaemia while driving you must stop as soon as safely possible – **do not ignore the warning symptoms.**

EARLY SYMPTOMS OF HYPOGLYCAEMIA INCLUDE:
Sweating, shakiness or trembling, feeling hungry, fast pulse or palpitations, anxiety, tingling lips.

If you don't treat this it may result in more severe symptoms such as:
Slurred speech, difficulty concentrating, confusion, disorderly or irrational behaviour, which may be mistaken for drunkenness.

If left untreated this may lead to unconsciousness.

What you need to tell us about
By law, you must tell us if any of the following applies:

- You suffer more than one episode of severe hypoglycaemia within the last 12 months. You must also tell us if you or your medical team feel you are at high risk of developing severe hypoglycaemia. For Group 2 drivers (bus/lorry), one episode of severe hypoglycaemia must be reported immediately.
- You develop impaired awareness of hypoglycaemia. (Difficulty in recognising the warning symptoms of low blood sugar).
- You suffer severe hypoglycaemia while driving.
- You need treatment with insulin.
- You need laser treatment to both eyes or in the remaining eye if you have sight in one eye only.
- you have problems with vision in both eyes, or in the remaining eye if you have sight in one eye only. By law, you must be able to read, with glasses or contact lenses if necessary, a car number plate in good daylight at 20 metres (65 feet). In addition, the visual acuity (with the aid of glasses or contact lenses if worn) must be at least 6/12 (0.5 decimal) with both eyes open, or in the only eye if monocular.
- you develop any problems with the circulation or sensation in your legs or feet which make it necessary for you to drive certain types of vehicles only, for example automatic vehicles or vehicles with a hand-operated accelerator or brake. This must be shown on your driving licence.
- an existing medical condition gets worse or you develop any other condition that may affect your driving safely.

In the interests of road safety, you must be sure that you can safely control a vehicle at all times.

How to tell us:

If your doctor, specialist or optician tells you to report your condition to us, you need to fill in a Medical Questionnaire about diabetes (DIAB1). You can download this from www.direct.gov.uk/driverhealth

Phone us on: 0300 790 6806
Write to: Driver's Medical Group, DVLA Swansea SA99 1TU

Useful addresses
Diabetes UK Cymru, Argyle House, Castlebridge, Cowbridge, Road East, Cardiff CF11 9AB
Diabetes UK Scotland, Savoy House, 140 Sauchiehall Street, Glasgow G2 3DH
Diabetic UK Central Office, Macleod House, 10 Parkway, London NW1 7AA
Diabetes UK website http://www.diabetes.org.uk *Ref: Tab1 - Rev Jan 13*

A Guide to Insulin Treated Diabetes and Driving

Drivers who have any form of diabetes treated with any insulin preparation must inform DVLA
(Caveat: See Temporary Insulin Treatment)

HYPOGLYCAEMIA

Hypoglycaemia (also known as a hypo) is the medical term for a low blood glucose (sugar) level.

Severe hypoglycaemia means the assistance of another person is required.

The risk of hypoglycaemia is the main danger to safe driving and this risk increases the longer you are on insulin treatment. This may endanger your own life as well as the other road users. Many of the accidents caused by hypoglycaemia are because drivers carry on driving even though they get warning symptoms of hypoglycaemia . If you get warning symptoms of hypoglycaemia whilst driving, you must always stop as soon as safely possible – **do not ignore the warning symptoms**.

EARLY SYMPTOMS OF HYPOGLYCAEMIA INCLUDE:

Sweating, shakiness or trembling, feeling hungry, fast pulse or palpitations, anxiety, tingling lips.

If you don't treat this it may result in more severe symptoms such as:

Slurred speech, difficulty concentrating, confusion, disorderly or irrational behaviour, which may be mistaken for drunkenness.

If left untreated this may lead to unconsciousness.

DRIVERS WITH INSULIN TREATED DIABETES ARE ADVISED TO TAKE THE FOLLOWING PRECAUTIONS.

- You should **always** carry your glucose meter and blood glucose strips with you. You should check your blood glucose no more than 2 hours before the start of the first journey and every two hours whilst you are driving. If driving multiple short journeys, you do not necessarily need to test before each additional journey as long as you test every 2 hours while driving. More frequent testing may required if for any reason there is a greater risk of hypoglycaemia for example after physical activity or altered meal routine. The intention is to ensure that blood glucose is always above 5 mmol/L while driving.
- In each case if your blood glucose is **5.0mmol/l or less, take a snack.** If lt is less than **4.0mmol/l or you feel hypoglycaemic, do not drive.**
- If hypoglycaemia develops while driving, stop the vehicle as soon as possible.
- You should switch off the engine, remove the keys from the ignition and move from the driver's seat.
- You should not start driving until 45 minutes after blood glucose has returned to normal. It takes up to 45 minutes for the brain to recover fully.
- Always keep an emergency supply of fast-acting carbohydrate such as glucose tablets or sweets within easy reach in the vehicle.
- You should carry personal identification to show that you have diabetes in case of injury in a road traffic accident.
- Particular care should be taken during changes of insulin regimens, changes of lifestyle, exercise, travel and pregnancy.
- You must take regular meals, snacks and rest periods on long journeys. Always avoid alcohol.

EYESIGHT

All drivers are required by law to read, in good daylight (with glasses or corrective lenses if necessary), a car number plate from a distance of 20 metres. In addition, the visual acuity (with the aid of glasses or contact lenses if worn) must be at least 6/12 (0.5 decimal) with both eyes open, or in the only eye if monocular.

LIMB PROBLEMS

Limb problems/amputations are unlikely to prevent driving. They may be overcome by driving certain types of vehicles e.g. automatics or one with hand controls.

YOU MUST INFORM DVLA IF:

- You suffer more than one episode of severe hypoglycaemia (<u>needing the assistance of another person</u>) within the last 12 months. For Group 2 drivers (bus/lorry) one episode of severe hypoglycaemia must be reported immediately. You must also tell us if you or your medical team feels you are at high risk of developing hypoglycaemia.
- You develop impaired awareness of hypoglycaemia. (difficulty in recognising the warning symptoms of low blood sugar)
- You suffer severe hypoglycaemia while driving.
- An existing medical condition gets worse or you develop any other condition that may affect you driving safely.

CONTACT US

Web site: http://www.dvla.gov.uk/motoring

Tel: 0300 790 6806 (8.00am. to 5.30pm. Mon – Fri) & (8.00 am. to 1pm. Saturday)

Write: Drivers' Medical Group, DVLA, Swansea SA99 1TU

For further informations on diabetes visit <u>www.diabetes.org.uk</u>

CHAPTER 4

PSYCHIATRIC DISORDERS

PSYCHIATRIC DISORDERS	**GROUP 1 ENTITLEMENT ODL - CAR, M/CYCLE**	**GROUP 2 ENTITLEMENT VOC – LGV/PCV (LORRY/BUS)**
ANXIETY OR DEPRESSION (**without** significant memory or concentration problems, agitation, behavioural disturbance or suicidal thoughts).	DVLA need not be notified and driving may continue. (See note about medication in Appendix at end of this Chapter).	Very minor short-lived illnesses need not be notified to DVLA. (See note about medication in Appendix at end of this Chapter)
MORE SEVERE ANXIETY STATES OR DEPRESSIVE ILLNESSES (**with** significant memory or concentration problems, agitation, behavioural disturbance or suicidal thoughts) NB: For cases, which **also** involve **persistent misuse of or dependence on alcohol/drugs**, please refer to the appropriate section of Chapter 5. Where psychiatric illness has been associated with substance misuse, continuing misuse is not acceptable for licensing.	**Driving should cease** pending the outcome of medical enquiry. A period of stability depending upon the circumstances will be required before driving can be resumed. Particularly dangerous are those who may attempt suicide at the wheel.	Driving may be permitted when the person is well and stable for a period of 6 months. Medication must not cause side effects, which would interfere with alertness or concentration. Driving is usually permitted if the anxiety or depression is long-standing, but maintained symptom-free on doses of psychotropic medication which do not impair. DVLA may require psychiatric reports. NB: It is the illness rather than the medication, which is of prime importance, but see notes on medication.
ACUTE PSYCHOTIC DISORDERS OF ANY TYPE NB: For cases, which also involve persistent misuse of or dependence on alcohol/drugs, please refer to the appropriate section of Chapter 5. Where psychiatric illness has been associated with substance misuse, continuing misuse is not acceptable for licensing.	**Driving must cease** during the acute illness. Re-licensing can be considered when **all** of the following conditions can be satisfied: (a) Has remained well and stable for at least 3 months. (b) Is compliant with treatment. (c) Is free from adverse effects of medication which would impair driving. (d) Subject to a favourable specialist report. Drivers who have a history of instability and/or poor compliance will require a longer period off driving.	**Driving must cease** pending the outcome of medical enquiry. It is normally a requirement that the person should be well and stable for 3 years (i.e. to have experienced a good level of functional recovery with insight into their illness and to be fully adherent to the agreed treatment plan, including engagement with the medical services) before driving can be resumed. In line with good practice, attempts should be made to achieve the minimum effective anti-psychotic dose; tolerability should be optimal and not associated with any deficits (e.g. in alertness, concentration and motor performance) that might impair driving ability. Where in patients with established illness the history suggests a likelihood of relapse, the risk should be appraised as low (either in the treated or untreated state). DVLA will normally require a consultant report that specifically addresses the relevant issues above before the licence can be considered.

See Appendix at end of this Chapter

PSYCHIATRIC DISORDERS	**GROUP 1 ENTITLEMENT** **ODL - CAR, M/CYCLE**	**GROUP 2 ENTITLEMENT** **VOC – LGV/PCV (LORRY/BUS)**
HYPOMANIA/MANIA NB: For cases, which also involve persistent misuse of or dependence on alcohol/drugs, please refer to the appropriate section of Chapter 5. Where psychiatric illness has been associated with substance misuse, continuing misuse is not acceptable for licensing.	**Driving must cease** during the acute illness. Following an **isolated episode**, re-licensing can be reconsidered when **all** the following conditions can be satisfied: (a) Has remained well and stable for at least 3 months. (b) Is compliant with treatment. (c) Has regained insight. (d) Is free from adverse effects of medication which would impair driving. (e) Subject to a favourable specialist report. **REPEATED CHANGES OF MOOD:** Hypomania or mania are particularly dangerous to driving when there are repeated changes of mood. Therefore, when there have been 4 or more episodes of mood swing within the previous 12 months, at least **6 months** stability will be required under condition (a), in addition to satisfying conditions (b) to (e).	**Driving must cease** pending the outcome of medical enquiry. It is normally a requirement that the person should be well and stable for 3 years (i.e. to have experienced a good level of functional recovery with insight into their illness and to be fully adherent to the agreed treatment plan, including engagement with the medical services) before driving can be resumed. In line with good practice, attempts should be made to achieve the minimum effective dose of psychotropic medication; tolerability should be optimal and not associated with any deficits (e.g. in alertness, concentration and motor performance) that might impair driving ability. Where in patients with established illness the history suggests a likelihood of relapse, the risk should be appraised as low (either in the treated or untreated state). DVLA will normally require a consultant report that specifically addresses the relevant issues above before the licence can be considered.
CHRONIC SCHIZOPHRENIA & Other Chronic Psychoses NB: For cases, which also involve persistent misuse of or dependence on alcohol/drugs, please refer to the appropriate section of Chapter 5. Where psychiatric illness has been associated with substance misuse, continuing misuse is not acceptable for licensing.	The driver must satisfy **all** the following conditions: (a) Stable behaviour for at least 3 months. (b) Is adequately compliant with treatment. (c) Remain free from adverse effects of medication, which would impair driving. (d) Subject to a favourable specialist report. **Continuing symptoms**: Even with limited insight, these do not necessarily preclude licensing. Symptoms should be unlikely to cause significant concentration problems, memory impairment or distraction whilst driving. Particularly dangerous, are those drivers whose psychotic symptoms relate to other road users.	**Driving must cease** pending the outcome of medical enquiry. It is normally a requirement that the person should be well and stable for 3 years (i.e. to have experienced a good level of functional recovery with insight into their illness and to be fully adherent to the agreed treatment plan, including engagement with the medical services) before driving can be resumed. In line with good practice, attempts should be made to achieve the minimum effective anti-psychotic dose; tolerability should be optimal and not associated with any deficits (e.g. in alertness, concentration and motor performance) that might impair driving ability. Where in patients with established illness the history suggests a likelihood of relapse, the risk should be appraised as low (either in the treated or untreated state). DVLA will normally require a consultant report that specifically addresses the relevant issues above before the licence can be considered.
DEVELOPMENTAL DISORDERS includes Asperger's Syndrome, autism, severe communication disorders and Attention Deficit Hyperactivity Disorder.	A diagnosis of any of these conditions is not in itself a bar to licensing. Factors such as impulsivity, lack of awareness of the impact of own behaviours on self or others need to be considered	Continuing minor symptomatology may be compatible with licensing. Cases will be considered on an individual basis.

See Appendix at end of this Chapter

DISORDER	GROUP 1 ENTITLEMENT ODL – CAR, M/CYCLE	GROUP 2 ENTITLEMENT VOC – LGV/PCV (LORRY/BUS)
MILD COGNITIVE IMPAIRMENT (MCI)	If there are no effects on driving then DVLA does not need to be notified; if however there are any concerns that driving may be adversely affected then DVLA should be notified to allow enquires to take place.	If there are no effects on driving then DVLA does not need to be notified; if however there are any concerns that driving may be adversely affected then DVLA should be notified to allow enquires to take place.
DEMENTIA OR ANY ORGANIC BRAIN SYNDROME	It is extremely difficult to assess driving ability in those with dementia. Those who have poor short-term memory, disorientation, lack of insight and judgement are almost certainly not fit to drive. The variable presentations and rates of progression are acknowledged. Disorders of attention will also cause impairment. A decision regarding fitness to drive is usually based on medical reports. In early dementia when sufficient skills are retained and progression is slow, a licence may be issued subject to annual review. A formal driving assessment may be necessary **(See Appendices 1 & 2).**	Refuse or revoke licence.
LEARNING DISABILITY severely below average general intellectual functioning accompanied by significant limitations in adaptive functioning in at least 2 of the following areas: communication, self-care, home-living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health and safety.	Severe learning disability is not compatible with driving and the licence application must be refused. In milder forms, provided there are no other relevant problems, it may be possible to hold a licence, but it will be necessary to demonstrate adequate functional ability at the wheel.	Permanent refusal or revocation if severe. Minor degrees of learning disability when the condition is stable with no medical or psychiatric complications may be compatible with the holding of a licence.
BEHAVIOUR DISORDERS includes post head injury syndrome and Non-Epileptic Seizure Disorder	If seriously disturbed e.g. violent behaviour or alcohol abuse and likely to be a source of danger at the wheel, licence would be revoked or the application refused. Licence will be issued after medical reports confirm that behavioural disturbances have been satisfactorily controlled.	Refusal or revocation if associated with serious behaviour disturbance likely to make the individual be a source of danger at the wheel. If psychiatric reports confirm stability, then consideration would be given to restoration of the licence.
PERSONALITY DISORDERS	If likely to be a source of danger at the wheel licence would be revoked or the application refused. Licensing would be permitted providing medical enquiry confirms that any behaviour disturbance is not related to driving or not likely to adversely affect driving or road safety.	Refusal or revocation if associated with serious behaviour disturbance likely to make the individual be a source of danger at the wheel. If psychiatric reports confirm stability, then consideration would be given to restoration of the licence

See Appendix at end of this Chapter

Appendix

PSYCHIATRIC NOTES

Important Note.

Other psychiatric conditions, which do not fit neatly into the aforementioned classification will need to be reported to DVLA **if causing or felt likely to cause** symptoms affecting safe driving. These would include for example any impairment of consciousness or awareness, any increased liability to distraction or symptoms affecting the safe operation of vehicle controls. The patient should be advised to declare both the condition and symptoms of concern.

It is the relationship of symptoms to driving that is of importance.

- The 2nd EC Directive requires member states to set minimum medical standards of fitness to drive and sets out the requirements for mental health in broad terms.
- The Directive makes a clear distinction between the standards needed for Group 1 (cars and motorcycles) and Group 2 (lorries and buses) licences. The standards for the latter being more stringent due to the size of vehicle and the greater time spent at the wheel during the course of the occupation.
- Severe mental disorder is a prescribed disability for the purposes of Section 92 of the Road Traffic Act 1988. Regulations define "severe mental disorder" as including mental illness, arrested or incomplete development of the mind, psychopathic disorder or severe impairment of intelligence or social functioning. The standards must reflect, not only the need for an improvement in the mental state, but also a period of stability, such that the risk of relapse can be assessed should the patient fail to recognise any deterioration.
- Misuse of or dependence on alcohol or drugs will require the standards in this chapter to be considered in conjunction with those of Chapter 5 of this publication.

MEDICATION

- Section 4 of the Road Traffic Act 1988 does not differentiate between illicit or prescribed drugs. Therefore, any person who is driving or attempting to drive on the public highway, or other public place whilst unfit due to any drug, is liable to prosecution.
- All drugs acting on the central nervous system can impair alertness, concentration and driving performance. This is particularly so at initiation of treatment, or soon after and when dosage is being increased. Driving must cease if adversely affected.
- The older tricyclic antidepressants can have pronounced anticholinergic and antihistaminic effects, which may impair driving. The more modern antidepressants may have fewer adverse effects. **These considerations need to be taken into account when planning the treatment of a patient who is a professional driver.**
- Anti-psychotic drugs, including the depot preparations, can cause motor or extrapyramidal effects as well as sedation or poor concentration, which may, either alone or in combination, be sufficient to impair driving. Careful clinical assessment is required.
- The epileptogenic potential of psychotropic medication should be considered particularly when patients are professional drivers.
- Benzodiazepines are the most likely psychotropic medication to impair driving performance, particularly the long acting compounds. **Alcohol will potentiate the effects.**
- Doctors have a duty of care to advise their patients of the potential dangers of adverse effects from medication and interactions with other substances, especially alcohol.
- Drivers with psychiatric illnesses are often safer when well and on regular psychotropic medication than when they are ill. Inadequate treatment or irregular compliance may render a driver impaired by both the illness and medication.

CONFIDENTIALITY

When a patient has a condition which makes driving unsafe and the patient is either unable to appreciate this, or refuses to cease driving, GMC guidelines advise breaking confidentiality and informing DVLA. [GMC Confidentiality Handbook]

PATIENTS UNDER SECTION 17 OF THE MENTAL HEALTH ACT (or comparable legislation in other UK jurisdictions)

Before resuming driving, drivers must be able to satisfy the standards of fitness for their respective conditions and be free from any effects of medication, which will affect driving adversely. The Responsible Clinician should give specific advice to the patient regarding driving during leave.

CHAPTER 5

DRUG AND ALCOHOL MISUSE AND DEPENDENCE

ALCOHOL PROBLEMS	GROUP 1 ENTITLEMENT ODL - CAR, M/CYCLE	GROUP 2 ENTITLEMENT VOC – LGV/PCV (LORRY/BUS)
ALCOHOL MISUSE There is no single definition which embraces all the variables in this condition but the following is offered as a guide: " a state which, because of consumption of alcohol, causes disturbance of behaviour, related disease or other consequences, likely to cause the patient, his/her family or society harm now, or in the future, and which may or may not be associated with dependence". Reference to ICD10 **F10.1** is relevant.	**ALCOHOL MISUSE** Persistent alcohol misuse, confirmed by medical enquiry and/or by evidence of otherwise unexplained abnormal blood markers, requires licence revocation or refusal until a minimum **six month** period of controlled drinking or abstinence has been attained, with normalisation of blood parameters. Patient to seek advice from medical or other sources during the period off the road.	**ALCOHOL MISUSE** Persistent alcohol misuse, confirmed by medical enquiry and/or by evidence of otherwise unexplained abnormal blood markers, requires revocation or refusal of a vocational licence until at least **one year** period of abstinence or controlled drinking has been attained, with normalisation of blood parameters. Patient to seek advice from medical or other sources during the period off the road.
ALCOHOL DEPENDENCE "A cluster of behavioural, cognitive & physiological phenomena that develop after repeated alcohol use & which include a strong desire to take alcohol, difficulties in controlling its use, persistence in its use despite harmful consequences, with evidence of increased tolerance and sometimes a physical withdrawal state." Indicators may include a history of withdrawal symptoms, of tolerance, of detoxification(s) and/or alcohol related fits.	**ALCOHOL DEPENDENCE** Alcohol dependence, confirmed by medical enquiry, requires licence revocation or refusal until a **one year** period free from alcohol problems has been attained. Abstinence will normally be required, with normalisation of blood parameters, if relevant.	**ALCOHOL DEPENDENCE** Vocational licensing will not be granted where there is a history of alcohol dependence within the past **three years**.
	LICENCE RESTORATION Will require satisfactory medical reports from own doctor(s) and may require independent medical examination and blood tests, arranged by DVLA. Consultant support/referral may be necessary.	**LICENCE RESTORATION** Will require satisfactory medical reports from own doctor(s) and may require independent medical examination and blood tests, arranged by DVLA. Consultant support/referral may be necessary.
Reference to ICD10 **F10.2 – F10.7 inclusive** is relevant	See also under **"Alcohol related seizures"**	See also under **"Alcohol related seizures"**

ALCOHOL PROBLEMS	**GROUP 1 ENTITLEMENT ODL - CAR, M/CYCLE**	**GROUP 2 ENTITLEMENT VOC – LGV/PCV (LORRY/BUS)**
Alcohol Related Seizure(s) Seizures associated with alcohol are not considered provoked for licensing purposes.	Following a solitary alcohol-related seizure, a licence will be revoked or refused for a minimum **six month** period from the date of the event. Should however the seizure have occurred on a background of alcohol the standards for such conditions will need to be satisfied before a new application can be considered. Where more than one seizure has occurred, the Epilepsy Regulations will apply **(See Appendix to Neuro Chapter for full details).** Medical enquiry will be required before licence restoration to confirm appropriate period free from persistent alcohol misuse and/or dependence. Independent medical assessment with blood analysis and consultant reports will normally be necessary.	Following a **solitary** alcohol-related seizure, a licence will be revoked or refused for a minimum **five year** period from the date of the event. Licence restoration thereafter requires: • No underlying cerebral structural abnormality • Off anti-epileptic medication for at least 5 years • Maintained abstinence from alcohol if previously dependent • Review by an addiction specialist & neurological opinion. Where **more than one seizure** has occurred or there is an underlying cerebral structural abnormality, the **Vocational Epilepsy Regulations** apply. (**See Appendix to Neuro Chapter for full details**)
ALCOHOL RELATED DISORDERS : e.g: hepatic cirrhosis with neuro-psychiatric impairment, psychosis.	**Driving should cease**. Licence to be refused/revoked until there is satisfactory recovery and is able to satisfy all other relevant medical standards.	Licence to be refused/revoked.

Appendix

HIGH RISK OFFENDER SCHEME for drivers convicted of certain drink/driving offences and meeting any of the following:

(a) One disqualification for driving, or being in charge of a vehicle, when the level of alcohol in the body equalled or exceeded:

i) 87.5 microgrammes per 100 millilitres of breath, or
ii) 200 milligrammes per 100 millilitres of blood, or
iii) 267.5 milligrammes per 100 millilitres of urine.

(b) Two disqualifications within the space of ten years for drinking and driving, or being in charge of a vehicle whilst under the influence of alcohol.

(c) One disqualification for refusing/failing to supply a specimen for analysis.

DVLA will be notified of such offenders by the courts. When an application for licence re-instatement is made, an independent medical examination will be conducted, which includes a questionnaire, serum AST, ALT, GGT and MCV assay and may include further assessments as indicated. If favourable, a “Till 70” licence is restored for Group I and a recommendation can be made regarding the issue of a Group 2 licence.

If a High Risk Offender has a previous history of alcohol dependence or persistent misuse, but has satisfactory examination and blood tests, a short period licence is issued for ordinary and vocational entitlement but dependent on their ability to meet the standard as specified.

A High Risk Offender found to have a current history of alcohol misuse/dependence and/or unexplained abnormal blood test analysis will have the application refused.

DRUG MISUSE AND DEPENDENCE Reference to **ICD**10 **F10.1-F10.7** inclusive is relevant.	**GROUP 1 ENTITLEMENT** **ODL - CAR, M/CYCLE**	**GROUP 2 ENTITLEMENT** **VOC – LGV/PCV (LORRY/BUS)**
Cannabis Amphetamines (*note: Methamphetamine below)* Ecstasy Ketamine & other psychoactive substances, including LSD and Hallucinogens	Persistent use of or dependence on these substances, confirmed by medical enquiry, will lead to licence refusal or revocation until a minimum **six month** period free of such use has been attained. For Ketamine misuse, 6 months off driving, drug-free, is required, and 12 months in the case of dependence. Independent medical assessment and urine screen arranged by DVLA, may be required.	Persistent use of or dependence on these substances will lead to refusal or revocation of a vocational licence for a minimum **one year** period free of such use has been attained. Independent medical assessment and urine screen arranged by DVLA, **will normally** be required.
Heroin Morphine Methadone* Cocaine Methamphetamine	Persistent use of, or dependence on these substances, confirmed by medical enquiry, will lead to licence refusal or revocation until a minimum **one year** period free of such use has been attained. Independent medical assessment and urine screen arranged by DVLA, may be required. In addition favourable Consultant or Specialist report **may** be required on reapplication. * Applicants or drivers **complying fully with a** Consultant supervised oral Methadone maintenance programme may be licensed, subject to favourable assessment and, normally, annual medical review. Applicants or drivers on an oral **buprenorphine** programme may be considered applying the same criteria. There should be no evidence of continuing use of other substances, including cannabis.	Persistent use of, or dependence on these substances, will require revocation or refusal of a vocational licence until a minimum **three year** period free of such use has been attained. Independent medical assessment and urine screen arranged by DVLA, **will normally** be required. In addition favourable Consultant or Specialist report will be required before relicensing. *Applicants or drivers complying fully with a Consultant supervised oral Methadone maintenance programme may be considered for an annual review licence once a minimum **three year** period of stability on the maintenance programme has been established, with favourable random urine tests and assessment. Expert Panel advice will be required in each case.
Benzodiazepines The non-prescribed use of these drugs and/or the use of supra-therapeutic dosage, whether in a substance withdrawal/maintenance programme or otherwise, constitutes misuse/dependence for licensing purposes. The prescribed use of these drugs at therapeutic doses (BNF), without evidence of impairment, does not amount to misuse/dependence for licensing purposes (although clinically dependence may exist).	Persistent misuse of, or dependence on these substances, confirmed by medical enquiry, will lead to licence refusal or revocation until a minimum one year period free of such use has been attained. Independent medical assessment and urine screen arranged by DVLA, may be required. In addition favourable Consultant or Specialist report **may** be required on reapplication.	Persistent misuse of, or dependence on these substances, will require revocation or refusal of a vocational licence for a minimum **three-year** period. Independent medical assessment and urine screen arranged by DVLA, **will normally** be required. In addition favourable Consultant or Specialist report will be required before relicensing.

Multiple substance misuse and/or dependence – including misuse with alcohol – is incompatible with licensing fitness

DRUG MISUSE AND DEPENDENCE Reference to **ICD**10 **F10.1-F10.7** inclusive is relevant.	**GROUP 1 ENTITLEMENT** **ODL - CAR, M/CYCLE**	**GROUP 2 ENTITLEMENT** **VOC – LGV/PCV (LORRY/BUS)**
Seizure(s) associated with drug misuse/dependence Seizures associated with drug misuse/dependence are not considered provoked for licensing purposes.	Following a **solitary** seizure associated with drug misuse or dependence, a licence will be refused or revoked for a minimum **six month** period from the date of the event. Should however the seizure have occurred on a background of substance misuse or dependence, the standards for such conditions will need to be satisfied before a new application can be considered. Where more than one seizure has occurred, the Epilepsy Regulations will apply **(See Appendix to Neuro Chapter for full details).** Medical enquiry will be required before licence restoration to confirm appropriate period free from persistent drug misuse and/or dependence. Independent medical assessment with urine analysis and consultant reports will normally be necessary.	Following a **solitary** seizure associated with drug misuse or dependence , a licence will be revoked or refused for a minimum **five-year** period from the date of the event. Licence restoration thereafter requires: • No underlying cerebral structural abnormality • Off anti-epileptic medication for at least 5 years • Maintained abstinence from drugs if previously dependent • Review by an addiction specialist & neurological opinion. Where **more than one seizure** has occurred or there is an underlying cerebral structural abnormality, the **Vocational Epilepsy Regulations** apply. (**See Appendix to Neuro Chapter for full details**)

NB: A person who has been re-licensed following persistent drug misuse or dependence must be advised as part of their after-care that if their condition recurs they should cease driving and notify DVLA Medical Branch.

CHAPTER 6

VISUAL DISORDERS

The law requires that a licence holder or applicant is considered as suffering a **prescribed disability** if unable to meet the eyesight requirements, i.e. to read in good daylight (with the aid of glasses or contact lenses if worn) a registration mark fixed to a motor vehicle and containing letters and figures 79 millimetres high and 50 millimetres wide (i.e. post 1.9.2001 font) at a distance of 20 metres, or at a distance of 20.5 metres where the characters are 79 millimetres high and 57 millimetres wide (i.e. pre 1.9.2001 font). If unable to meet this standard, the driver must not drive and the licence must be refused or revoked.

GB law also requires that a licence be refused or revoked if DVLA considers a person has any other relevant disability which makes them a likely source of danger to the public when driving. DVLA would, in particular, consider anyone whose eyesight is below any EU minimum standard to be a source of danger when driving.

Registration for sight impairment or severe sight impairment will normally be regarded as incompatible with holding a driving licence and should be notified. However, attention will be given to the standards indicated below in deciding on fitness to drive.

VISUAL DISORDERS	**GROUP 1 ENTITLEMENT** **ODL - CAR, M/CYCLE**	**GROUP 2 ENTITLEMENT** **VOC – LGV/PCV (LORRY/BUS)**
ACUITY	Must be able to meet the above prescribed standard for reading a number-plate. In addition, the visual acuity (with the aid of glasses or contact lenses if worn) must be at least 6/12 (Snellen decimal 0.5) with both eyes open, or in the only eye if monocular. .	Drivers must have a visual acuity, using corrective lenses if necessary, of at least 6/7.5 (0.8 decimal) in the better eye and at least 6/60 (Snellen decimal 0.1) in the other eye. Where glasses are worn to meet the minimum standards, they should have a corrective power ≤ +8 dioptres. It is also necessary for all drivers of Group 2 vehicles to be able to meet the prescribed and relevant Group 1 visual acuity requirements. * / *** Grandfather Rights on the page below.
CATARACT Includes severe bilateral cataracts, failed bilateral cataract extractions and post cataract surgery where these are affecting the eyesight.	Must be able to meet the above eyesight requirements. In the presence of cataract, glare may affect the ability to meet the number plate requirement, even with apparently appropriate acuities.	Must be able to meet the above prescribed acuity requirements. In the presence of cataract, glare may affect the ability to meet the number plate requirement, even with appropriate acuities.
MONOCULAR VISION (includes the use of one eye only for driving)	**Complete** loss of vision in one eye (ie. If there is any light perception, driver is not considered monocular). Must notify DVLA. Must meet same visual acuity and visual field standards as binocular drivers, but may drive when clinically advised that has adapted to the condition.	**Complete** loss of vision in one eye or corrected acuity of less than 3/60 (Snellen decimal 0.05) in one eye. Applicants are barred in law from holding a Group 2 licence. It is necessary for all drivers of Group 2 vehicles to be able to meet the prescribed and relevant Group 1 visual acuity requirements. **/*** Grandfather Rights on the page below.

See Appendix at end of this Chapter

VISUAL DISORDERS	GROUP 1 ENTITLEMENT ODL - CAR, M/CYCLE	GROUP 2 ENTITLEMENT VOC – LGV/PCV (LORRY/BUS)
VISUAL FIELD DEFECTS Disorders such as severe bilateral glaucoma, severe bilateral retinopathy, retinitis pigmentosa and other disorders producing field defect including partial or complete homonymous hemianopia/quadrantanopia or complete bitemporal hemianopia.	**Driving must cease unless** confirmed able to meet recommended national guidelines for visual field. (See appendix at end of Chapter for full definition and for conditions to be met for consideration as an exceptional case on an individual basis)	The horizontal visual field should be at least 160 degrees, the extension should be at least 70 degrees left and right and 30 degrees up and down. No defects should be present within a radius of the central 30 degrees.
DIPLOPIA	**Cease driving on diagnosis**. Resume driving on confirmation to the Licensing Authority that the diplopia is controlled by glasses or by a patch which the licence holder undertakes to wear while driving. (If patching, note requirements above for monocularity). **Exceptionally** a stable uncorrected diplopia of 6 months' duration or more may be compatible with driving if there is consultant support indicating satisfactory functional adaptation.	Permanent refusal or revocation if insuperable diplopia. Patching is not acceptable.
NIGHT BLINDNESS	Acuity and field standards must be met. Cases will be considered on an individual basis.	Group 2 acuity and field standards must be met and cases will then be considered on an individual basis.
COLOUR BLINDNESS	Need not notify DVLA. Driving may continue with no restriction on licence.	Need not notify DVLA. Driving may continue with no restriction on licence.
BLEPHAROSPASM	Consultant opinion required. If mild, driving can be allowed subject to satisfactory medical reports. Control of **mild** blepharospasm with botulinum toxin **may** be acceptable provided that treatment does not produce debarring side effects such as uncontrollable diplopia. DVLA should be informed of any change or deterioration in condition. Driving is not normally permitted if condition severe, and affecting vision, even if treated.	Consultant opinion required. If mild, driving can be allowed subject to satisfactory medical reports. Control of **mild** blepharospasm with botulinum toxin **may** be acceptable provided that treatment does not produce debarring side effects such as uncontrollable diplopia. DVLA should be informed of any change or deterioration in condition. Driving is not permitted if condition severe, and affecting vision, even if treated.

See Appendix at end of this Chapter

NB: Before the exceptions *-* can be accepted, the driver or applicant must meet all of the Group 1 acuity standards.**

*** Must have held the Group 2 licence on either BOTH 01.01.1983 and 01.04.1991 OR on 01.03.1992 and be able to complete a satisfactory certificate of experience to be eligible. If obtained first Group 2 licence between 02.03.1992 and 31.12.1996 uncorrected visual acuity may be worse than 3/60 in one eye.**

**** Group 2 licence must have been issued prior to 01.01.1991 in knowledge of monocularity.**

***** Monocularity is acceptable for C1 applicants who passed the ordinary driving test prior to 01.01.1997 if they satisfy the number-plate test, the visual acuity standard and the visual field requirement for the remaining eye.**

Appendix

FIELD OF VISION REQUIREMENT FOR THE HOLDING OF GROUP I LICENCE ENTITLEMENT

The minimum field of vision for safe driving is defined as "a field of at least 120° on the horizontal measured using a target equivalent to the white Goldmann III4e settings; the extension should be at least 50° left and right. In addition, there should be no **significant** defect in the binocular field which encroaches within 20° of fixation above or below the horizontal meridian".

This means that homonymous or bitemporal defects, which come close to fixation, whether hemianopic or quadrantanopic, are not normally accepted as safe for driving.

If a visual field assessment is necessary to determine fitness to drive, DVLA requires this to be a binocular Esterman field. Monocular full field charts may also be requested in specific conditions. Exceptionally, Goldmann perimetry, carried out to strict criteria, will be considered. The Secretary of State's Advisory Panel for Visual Disorders and Driving advises that, for an Esterman binocular chart to be considered reliable for licensing, the false positive score must be no more than 20%. When assessing monocular charts and Goldmann perimetry, fixation accuracy will also be considered.

The interpretation of visual field charts for the purposes of driver licensing described below refers to perimetry performed on a Humphrey Field Analyser.

Defect affecting central area ONLY (Esterman)
For GROUP 1 licensing purposes, pending the outcome of current research, the following are generally regarded as **acceptable central** loss:

- Scattered single missed points
- A single cluster of up to 3 adjoining points

For GROUP 1 licensing purposes the following are generally regarded as **unacceptable (i.e. 'significant') central** loss:

- A cluster of 4 or more adjoining points that is either wholly **or partly** within the central 20 degree area
- Loss consisting of both a single cluster of 3 adjoining missed points up to and including 20 degrees from fixation, **and any** additional separate missed point(s) within the central 20 degree area
- **Any** central loss that is an **extension** of a hemianopia or quadrantanopia of size greater than 3 missed points.

Defect affecting the peripheral areas – width assessment
For GROUP 1 licensing, the following will be disregarded when assessing the width of field:

- A cluster of **up to three** adjoining missed points, unattached to any other area of defect, lying on or across the horizontal meridian
- A vertical defect of only single point width but of any length, unattached to any other area of defect, which touches or cuts through the horizontal meridian.

Exceptional cases
GROUP 1 drivers who have previously held **full driving entitlement**, removed because of a field defect which does not satisfy the standard, may be eligible to reapply to be considered as exceptional cases on an individual basis, subject to strict criteria:

- The defect must have been present for at least 12 months
- The defect must have been caused by an isolated event or a non-progressive condition
- There must be no other condition or pathology present which is regarded as progressive and likely to be affecting the visual fields.
- The applicant has sight in both eyes
- There is no uncontrolled diplopia
- There is no other impairment of visual function, including glare sensitivity, contrast sensitivity or impairment of twilight vision.
- There is clinical confirmation of full functional adaptation

If reapplication is then accepted, a satisfactory practical driving assessment, carried out at an approved assessment centre, must subsequently be completed.

A process is now in place for applications for a provisional driving licence in those with a static visual field defect. Details may be found on the DVLA website at: www.dft.gov.uk/dvla/medical.aspx .

Note: An individual who is monocular cannot be considered under exceptional case criteria

CHAPTER 7

RENAL DISORDERS

RENAL DISORDERS	GROUP 1 ENTITLEMENT ODL - CAR, M/CYCLE	GROUP 2 ENTITLEMENT VOC – LGV/PCV (LORRY/BUS)
CHRONIC RENAL FAILURE CAPD (Continuous ambulatory peritoneal dialysis) Haemodialysis	No restriction on holding a Till 70 licence unless subject to severe electrolyte disturbance or significant symptoms, e.g. sudden disabling attacks of giddiness or fainting or impaired psychomotor or cognitive function when the licence may be revoked or the application refused.	Drivers with these disabilities **will be assessed individually** by DVLA against the criteria as shown in the Group 1 Entitlement..
All other renal disorders	Need not notify DVLA unless associated with a relevant disability.	Need not notify DVLA unless associated with significant symptoms or a relevant disability.

RESPIRATORY DISORDERS

RESPIRATORY and SLEEP DISORDERS	GROUP 1 ENTITLEMENT ODL - CAR, M/CYCLE	GROUP 2 ENTITLEMENT VOC – LGV/PCV
COUGH SYNCOPE	**Driving must cease** for 6 months if a single episode increased to 12 months if multiple attacks. Reapplication may be considered at an earlier time if the following can be satisfied: Any underlying chronic respiratory condition is well controlled, smoking cessation, BMI < 30, gastro oesophageal reflux treated.	5 years off driving from the date of the last attack. Reapplication at 1 year if the following can be satisfied: Any underlying chronic respiratory condition is well controlled, smoking cessation, BMI < 30, gastro oesophageal reflux treated. This shall require confirmation by specialist opinion.
RESPIRATORY DISORDERS including asthma, COPD (Chronic Obstructive Pulmonary Disease)	DVLA need not be notified **unless** attacks are associated with disabling giddiness, fainting or loss of consciousness.	As for Group 1 licence.
CARCINOMA OF LUNG	DVLA need not be notified **unless** cerebral secondaries are present. (See Chapter 1 for malignant brain tumour)	Those drivers with non small cell lung cancer classified as T1N0M0 can be considered on an individual basis. In other cases, driving must cease until 2 years has elapsed from the time of definitive treatment. Driving may resume providing treatment satisfactory and no brain scan evidence of intracranial metastases.

CHAPTER 8

MISCELLANEOUS CONDITIONS

MISCELLANEOUS CONDITIONS	GROUP 1 ENTITLEMENT ODL - CAR, M/CYCLE	GROUP 2 ENTITLEMENT VOC – LGV/PCV (LORRY/BUS)
EXCESSIVE SLEEPINESS To include: 1) Obstructive Sleep Apnoea syndrome. 2) Any other condition or medication that may cause excessive sleepiness severe enough to likely impair safe driving. Further information can be found on leaflet **"INF159"** http://www.dvla.gov.uk/dvla/~/media/pdf/leaflets/INF159.ashx?	Driving must cease **until** satisfactory control of symptoms has been attained.	**Driving must cease until** satisfactory control of symptoms has been attained, with ongoing compliance with treatment, confirmed by consultant / specialist opinion. Regular, normally annual, licensing review required.
DEAFNESS (PROFOUND)	Need not notify DVLA. Till 70 issued/retained.	Of paramount importance is the proven ability to be able to communicate in the event of an emergency by speech or by using a device e.g. a MINICOM. If unable so to do the licence is likely to be refused or revoked.
CANCERS NOT ALREADY COVERED IN EARLIER SECTIONS	See Below	See Below
For all tumours, fitness to drive depends upon: • The prospective risk of a seizure: For Group 1 entitlement DVLA does not need to be notified unless there are cerebral metastases or significant complications of relevance (see subsequent bullet points for guidance). For Group 2 entitlement (VOC), specific attention is paid to the risk of cerebral metastasis. • Specific limb impairment, e.g. from bone primary or secondary cancer. • General state of health. Advanced malignancies causing symptoms such as general weakness or cachexia to such an extent that safe driving would be comprised is not acceptable for safe driving. For eye cancers, the vision requirements must be met as well as the above.		
AIDS Syndrome	Driving may continue providing medical enquiries confirm no relevant associated disability likely to affect driving. 1, 2 or 3-year licence with medical review	Cases will be assessed on an individual basis. In the absence of any debarring symptoms CD4 count will need to be maintained at 200 or above for at least 6 months to be eligible.
HIV positive	Need not notify DVLA.	Need not notify DVLA

MISCELLANEOUS CONDITIONS	GROUP 1 ENTITLEMENT ODL - CAR, M/CYCLE	GROUP 2 ENTITLEMENT VOC – LGV/PCV (LORRY/BUS)
AGE (Older Drivers)	Age is no bar to the holding of a licence. DVLA requires confirmation at age of 70 that no medical disability is present, thereafter a 3-year licence is issued subject to satisfactory completion of medical questions on the application form. However, as ageing progresses, a driver or his/her relative(s) may be aware that the combination of progressive loss of memory, impairment in concentration and reaction time with possible loss of confidence, suggest consideration be given to cease driving. Physical frailty is not per se a bar to the holding of a licence.	Re-application with medical confirmation of continuing satisfactory fitness is required at age 45 and 5-yearly thereafter until 65, when annual application is required.
HYPOGLYCAEMIA FROM ANY CAUSE OTHER THAN THE TREATMENT OF DIABETES	If suffering episodes of severe hypoglycaemia should cease driving while liable to these episodes. Examples would include after bariatric surgery or in association with eating disorders.	If suffering episodes of severe hypoglycaemia should cease driving while liable to these episodes. Example would include after bariatric surgery or in association with eating disorders.

IMPAIRMENT OF COGNITIVE FUNCTION

e.g. post stroke, post head injury, early dementia

There is no single or simple marker for assessment of impaired cognitive function although the ability to manage day to day living satisfactorily is a possible yardstick of cognitive competence. In-car assessments, on the road with a valid licence, are an invaluable method of ensuring that there are no features present liable to cause the patient to be a source of danger, e.g. visual inattention, easy distractibility, and difficulty performing multiple tasks. In addition it is important that reaction time, memory, concentration and confidence are adequate and do not show impairment likely to affect driving performance.

COGNITIVE DISABILITY

Group 2
Impairment of cognitive functioning is not usually compatible with the driving of these vehicles.
Mild cognitive disability may be compatible with safe driving and individual assessment will be required.

Appendix 1

DISABLED DRIVERS

CARS (Group 1)
Driving is possible in both static and progressive or relapsing disorders but vehicle modification may be needed.

1) Permanent Limb Disabilities/ Spinal Disabilities	e.g. Amputation, Hemiplegia/Cerebral Palsy, Ankylosing Spondylitis, Severe Arthritis, especially with pain
2) Chronic Neurological Disorders:	e.g. Multiple Sclerosis, Parkinson's Disease, Motor Neurone Disease, peripheral neuropathy

Sophisticated vehicle adaptation is now possible and varies from automatic transmission to joy sticks and infra red controls for people with severe disabilities.

The DVLA will need to know which, if any, of the controls require to be modified and will ask the patient to complete a simple questionnaire. The driving licence will then be coded to reflect the modifications. A list of assessment centres is available at appendix 2, which will be able to give advice should the licence holder require it.

NB: A person in receipt of the higher rate mobility component of the Disability Living Allowance may hold a driving licence from 16 years of age.

LGV/PCV (Group 2)
Some disabilities **may** be compatible with the driving of large vehicles if mild and non-progressive. Individual assessment will be required.

ELECTRICALLY PROPELLED INVALID CARRIAGES (CLASS 2 & 3)

Class 2 vehicles are limited to 4 miles per hour and Class 3 vehicles to 8 miles per hour whilst on the road.

Users of these vehicles are not required to hold a driving licence and so are not required to meet the medical standards required of drivers of motor vehicles. However, individuals whose medical condition may affect their ability to drive an invalid carriage safely are advised to consult their GP before using these vehicles. We also recommend that the user is able to read a car number plate from a distance of 12.3 metres (40 ft). For further details please refer to the publication "Code of Practice for Class 3 Vehicle Users" available from the Mobility & Inclusion Unit, Department for Transport, Great Minster House, 76 Marsham Street, London SW1P 4DR; Tel: 0207 944 4461; Fax: 0207 944 6102; Email: miu@dft.gsi.gov.uk

Appendix 2

FORUM of MOBILITY CENTRES

Freefone: Tel: 0800 5593636
www.mobility-centres.org.uk/

BIRMINGHAM: (Incorporating satellite centres at Cannock, Staffordshire & Northampton). Worcester & Leamington Spa Tel: 0845 337 1540 Fax: 0121 333 4568 **I D P T**	Regional Driving Assessment Centre, Unit 11, Network Park, Duddeston Mill Road, Saltley, Birmingham B8 1AU Email: info@rdac.co.uk Website: www.rdac.co.uk
BODELWYDDAN: (Incorporating a satellite centre at. Newtown, Powys) Tel: 01745 584 858 Fax: 01745 535 042 **I D P T A W G**	North Wales Mobility and Driving Assessment Service, The Disability Resources Centre, Glan Clwyd Hospital, Bodelwyddan, Denbighshire, LL18 5UJ. Email: mobilityinfo@btconnect.com
BRISTOL: Tel: 0117 965 9353 Fax: 0117 965 3652 **I D P W T**	Mobility Service at Living (dlc) The Vassall Centre, Gill Avenue, Fishponds, Bristol, BS16 2QQ. Email: mobserv@thisisliving.org.uk Website: www.thisisliving.org.uk
CARDIFF: (Incorporating a satellite centre at Pembroke Dock) Tel/Fax: 029 2055 5130 **I D P G**	South Wales Mobility and Driving Assessment Service, Rookwood Hospital, Fairwater Road, Llandaff, Cardiff, CF5 2YN. Email: helen@waddac.co.uk
CARSHALTON: Tel: 020 8770 1151 Fax: 020 8770 1211 **I D P W** (advice on electric scooters and wheelchairs not manuals) **T** Also training course	QEF Mobility Services, 1 Metcalfe Avenue, Carshalton Surrey, SM5 4AW (for satnav please use SM5 4NR) Email: mobility@qef.org.uk/ Website: www.qef.org.uk
DERBY Tel: 01332 371929 Fax: 01332 382377 **I D P T A**	Derby DrivAbility, Kingsway Hospital, Kingsway, Derby, DE22 3LZ. Email: driving@derbyhospitals.nhs.uk Website: http://www.derbydrivability.com

EDINBURGH: (Incorporating Mobile Driving Assessment at other hospital sites in Scotland: Aberdeen, Inverness, Dundee Paisley, Irvine and Dumfries). Tel: 0131 537 9192 Fax: 0131 537 9193 **I D P**	Scottish Driving Assessment Service, Astley Ainslie Hospital, 133, Grange Loan, Edinburgh, EH9 2HL Email: marlene.mackenzie@nhslothian.scot.nhs.uk
HULL Tel: 0845 337 1540 Fax: 0121 333 4568 **I D P T**	c/o Regional Driving Assessment Centre, Unit 11, Network Park, Duddeston Mill Road, Saltley, Birmingham, B8 1AU Email: info@rdac.co.uk Website: www.rdac.co.uk
LEEDS: (Incorporating a satellite centre at York) Tel: 0113 305 5288 Fax: 0113 231 9291 **I D P W**	William Merritt Disabled Living Centre and Mobility Service, St Mary's Hospital, Green Hill Road, Armley, Leeds, LS12 3QE. Email: mobility.service@nhs.net Website: http://www.williammerrittleeds.org
MAIDSTONE (Incorporating satellite centres at Herne Bay, Kent & Hailsham, East Sussex) Tel: 01622 606900 Fax: 01622 606901 **I D P**	South East DriveAbility, Kent Community Health NHS Trust St Laurence Avenue 20/20 Business Park Allington Maidstone Kent, ME16 0LL Email: wk-pct.sedriveability@nhs.net Website: www.kentcht.nhs.uk/our-services/specialist-clinical-services/south-east-drive-ability
NEWCASTLE UPON TYNE: (Incorporating satellite centre at Penrith, Cumbria) Tel: 0191 287 5090 Fax: **I D P T**	North East Drive Mobility Northumberland, Tyne and Wear NHS Foundation Trust Walkergate Park Centre for Neuro-rehabilitation and Neuro-psychiatry Benfield Road Newcastle upon Tyne NE6 4QD Email: northeast.drivemobility@ntw.nhs.uk Website: www.ntw.nhs.uk/mobility
OXFORD: Tel: 0845 337 1540 Fax : 0121 333 4568 **I D P T**	c/o Regional Driving Assessment Centre Unit 11 Network Park Duddeston Mill Road Birmingham B8 1AU Email: info@rdac.co.uk Website: www.rdac.co.uk

SOUTHAMPTON (Incorporating satellite centres at Salisbury, Wilts & Basingstoke) Tel: 023 8051 2222 **I D P T**	Wessex DriveAbility, Leornain House Portswood, Southampton SO17 2LJ. Email: enquiries@wessexdriveability.org.uk Website: www.wessexdriveability.org.uk
THETFORD (Incorporating satellite centres at Colchester, Essex & Spalding, Lincs) Tel: 01842 753 029 Fax: 01842 755 950 **I D P W T**	East Anglian DriveAbility, 2, Napier Place, Thetford, Norfolk, IP24 3RL. Email: info@eastangliandriveability.org.uk Website: www.eastangliandriveability.org.uk
TRURO (Incorporating satellite centres at Exeter, Plymouth, Holsworthy, & Devon) Tel: 01872 254920 Fax: 01872 254921 **I D P W T A** Also wheelchair repairs, Independent Living and Drop-in Centre	Cornwall Mobility Centre, Tehidy House, Royal Cornwall Hospital, Truro, Cornwall, TR1 3LJ. Email: mobility@rcht.cornwall.nhs.uk Website: http://www.cornwallmobilitycentre.co.uk
WELWYN GARDEN CITY (Incorporating a satellite centre at Luton and Dunstable) Tel: 01707 324 581 Fax: 01707 371 297 **I D P W T**	Hertfordshire Action on Disability Mobility Centre, The Woodside Centre, The Commons, Welwyn Garden City, Hertfordshire, AL7 4DD. Email: driving @hadnet.org.uk Website: http://www.hadnet.org.uk/
WIGAN (Incorporating a satellite centre at Manchester) Tel: 01257 256409 Fax: 01257 256538 **I D P (T** only following assessment in certain cases)	Wrightington Mobility Centre, Wrightington Hospital, Hall Lane, Appley Bridge, Wigan, Lancashire, WN6 9EP. Email: mobility.centre@alwpct.nhs.uk

KEY TO FACILITIES AT THE CENTRES

I Free Information Service for disabled and older people, their families and professionals.
D Advice on vehicle adaptations, ability to learn, continue or return to driving.
P Assessment and advice for passengers getting in and out of vehicles and about safe loading of wheelchairs and other equipment.
W Advice on the selection and use of wheelchairs (powered and manually propelled) and scooters.
T Driving tuition, for novice drivers, those returning to driving after a break and those changing to a different method of vehicle control.
A Fitting of car adaptations for both drivers and passengers with disabilities.
G Advice and assessment for disabled drivers who require to drive LGV, PCV

INDEX

A

ABSCESS (INTRACEREBRAL) 16
ACOUSTIC NEUROMA/SCHWANNOMA 11
ACUITY 42
ACUTE CORONARY SYNDROMES 20
ACUTE ENCEPHALITIC ILLNESS AND MENINGITIS 9
ACUTE PSYCHOTIC DISORDERS OF ANY TYPE 34
AGE (OLDER DRIVERS) 46
AIDS 46
ALCOHOL MISUSE/DEPENDENCE 38
ALCOHOL SEIZURES/DISORDERS 5, 38-39
ALZHEIMERS DISEASE 36
AMAUROSIS FUGAX 8
ANEURYSM (AORTIC) 23
ANGINA (STABLE OR UNSTABLE) 20
ANGIOGRAPHY (CORONARY) 28
ANXIETY 34
AORTIC DISSECTION (CHRONIC) 24
ARACHNOID CYSTS 9
ARRHYTHMIA 21
ARRHYTHMOGENIC RIGHT VENTRICULAR CARDIOMYOPATHY (ARVC) 25
ARTERIOVENOUS MALFORMATION 14
ASPERGER'S SYNDROME 35
ASTHMA 45
ATRIAL DEFIBRILLATOR 21
ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD) 36
AUTISM 35
AUTISTIC SPECTRUUM DISORDER 35

B

BEHAVIOUR DISORDERS 36
BENIGN INFRATENTORIAL TUMOUR 11
BENIGN SUPRATENTORIAL TUMOUR 10
BIPOLAR ILLNESS 35
BLEPHAROSPASM 43
BRAIN TUMOURS 9-11

C

CABG 20
CANCER OTHER 46
CAPD (continuous ambulatory peritoneal dialysis) 45
CARCINOMA OF LUNG 45
CARDIAC RESYNCHRONISATION THERAPY (CRT) 26
CARDIOMYOPATHY (Hypertrophic) 25
CARDIOMYOPATHY (Dilated) 25
CAROTID ARTERY STENOSIS 24
CATARACT 42
CATHETER ABLATION 21
CAVERNOUS MALFORMATION 15
CHRONIC NEUROLOGICAL DISORDERS 7, 48
CHRONIC RENAL FAILURE 45
CHRONIC SUBDURAL 12
COPD (chronic obstructive pulmonary disease) 45

C cont'd

COLOUR BLINDNESS 43
COLLOID CYSTS 9
CONGENITAL HEART DISEASE 27
CORONARY ANGIOGRAPHY 28
COUGH SYNCOPE 45
CRANIOTOMY 9, 15

D

DEFIBRILLATOR – CARDIOVERTER 21-23
DEAFNESS 46
DEMENTIA 36
DEPRESSION 34
DEVELOPMENTAL DISORDERS 35
DIABETES – ALL ASPECTS 29-33
DIABETES leaflet TAB1 (INF188/2) 32
DIABETES leaflet DIABINF 33
DIPLOPIA 43
DISABLED DRIVERS 48
DISABLED DRIVERS ASSESSMENT CENTRES 49-51
DRIVING AFTER SURGERY 4
DRUG MISUSE/DEPENDENCY 5, 40-41
DURAL AV FISTULA 15
DVLA Contact Details 4

E

ECG ABNORMALITY 27
ECLAMPTIC SEIZURES 19
ENCEPHALITIC ILLNESS 9
EPILEPSY 5
EPILEPSY REGULATIONS 17
ETT and HYPERTROPHIC CARDIOMYOPATHY 28
EXCESSIVE SLEEPINESS 46
EXERCISE TESTING 28
EXTRAVENTRICULAR DRAIN 16

F

FIELD OF VISION REQUIREMENTS
Group 1 Licence Entitlement 44

G

GIDDINESS 8
GLAUCOMA 43
GLIOMAS 11

H

HAEMATOMA – INTRACEREBRAL 14
HEAD INJURY – TRAUMATIC 12
HEART FAILURE 25
HEART/HEART AND LUNG TRANSPLANT 26
HEART VALVE DISEASE 26
HEMIANOPIA 43
HIGH RISK OFFENDER SCHEME 39

H cont'd

HIV POSITIVE 46
HUNTINGTONS DISEASE 7, 48
HYDROCEPHALUS 16
HYPERTENSION 24
HYPERTROPHIC CARDIOMYOPATHY 25
HYPOGLYCAEMIA 29-33, 47
HYPOMANIA/MANIA 35

I

ICD 22-23
IMPAIRMENT DUE TO MEDICATION 3
IMPAIRMENT OF COGNITIVE FUNCTION 47
IMPAIRMENT SECONDARTY TO MULTIPLE MEDICAL CONDITIONS 3
IMPLANTED ELECTRODES 16
INFRATENTORIAL AVMs 14
INTRACEREBRAL ABSCESS 16
INTRACRANIAL PRESSURE MONITOR 16
INTRAVENTRICULAR SHUNT 16
ISOLATED SEIZURE 5

L

LEARNING DISABILITY 36
LEFT BUNDLE BRANCH BLOCK 27
LEFT VENTRICULAR ASSIST DEVICES 26
LOSS OF CONSCIOUSNESS/LOSS OF OR ALTERED AWARENESS 6-7

M

MALIGNANT TUMOURS 11
MARFAN'S SYNDROME 24
MENINGIOMA 10
MENINGITIS 8
MILD COGNITIVE IMPAIRMENT (MCI) 36
MONOCULAR VISION 42
MOTOR CORTEX STIMULATOR 16
MOTOR NEURONE DISEASE 7, 48
MULTIPLE SCLEROSIS 7, 48
MUSCLE DISORDERS 7
MYOCARDIAL INFARCTION 27

N

NEUROENDOSCOPIC PROCEDURES 16
NIGHT BLINDNESS 43
NON EPILEPTIC SEIZURE ATTACKS 5

O

OBSTRUCTIVE SLEEP APNOEA SYNDROME 45
ORGANIC BRAIN SYNDROME 36

P

PACEMAKER IMPLANT 21
PARKINSONS DISEASE 8, 48
PERCUTANEOUS CORONARY INTERVENTION 20

P cont'd

PERIPHERAL ARTERIAL DISEASE 24
PERIPHERAL NEUROPATHY 30, 48
PERSONALITY DISORDER 36
PITUITARY TUMOUR 9
POLICE, AMBULANCE (Health Service Vehicle) Information 2, 31
PRE-EXCITATION 27
PRIMARY/CENTRAL HYPERSOMIAS 7
PROVOKED SEIZURES 5, 19
PSYCHIATRIC NOTES 37
PSYCHOSIS 35,39

R

REFLEX VASOVAGAL SYNCOPE 6
RENAL DISORDERS 45
RESPIRATORY DISORDERS 45

S

SCHIZOPHRENIA 35
SEATBELT EXEMPTION 2
SEIZURES 5, 8-10, 15-19, 38-41
SPONTANEOUS ACUTE SUBDURAL HAEMATOMA 12
STROKES/TIAs 8
SUBARACHNOID HAEMORRHAGE 12
SUBDURAL EMPYEMA 16
SUBSTANCE MISUSE 5, 19, 35, 40
SUPRATENTORIAL AVMs 14
SYNCOPAL ATTACKS 27, 45

T

TAXI LICENSING 2
TIA 8
TRANSIENT GLOBAL AMNESIA 9
TRANSIENT ARRHYTHMIAS 21
TRANSPHENOIDAL SURGERY 9
TRAUMATIC BRAIN INJURY 12

U

UNPACED CONGENITAL COMPLETE HEART BLOCK 21

V

VALVE HEART DISEASE 26
VENTRICULAR CARDIOMYOPATHY 25
VISUAL ACUITY 42
VISUAL FIELD DEFECTS 43
VISUAL FIELD REQUIREMENTS 44

W

WITHDRAWAL OF ANTI-EPILEPSY MEDICATION 19

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