MEDICAL IN CONFIDENCE
NEURO2

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Rev Oct 11

Please write clearly and with black ink.
Questionnaire to assess your patient's medical fitness to drive

1. **Please indicate diagnosis**.

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If your patient has been diagnosed with a Brain Tumour, please enclose copies of the most recent Brain scan

	DD	MM	YY
2. Date of onset of your patient's symptoms.			
3. Date your patient was last seen by you and assessed for this condition:			

4. Please give the name, dosage and reason for current medication:

Name of medication	Dosage	Reason

5. Does your patient currently experience side-effects from their medication which are likely to impair safe driving? N/A ☐ YES ☐ NO ☐

6. Does your patient show evidence of cognitive impairment? YES ☐ NO ☐
If **YES** please answer the following;

6a. Does your patient show **significant** impairment of memory sufficient to cause disorientation? YES ☐ NO ☐

6b. Does your patient lack insight and/ or judgement to a degree that would make driving dangerous? YES ☐ NO ☐

6c. Does your patient show significant impairment in their ability to perform the activities of daily living? YES ☐ NO ☐
If **YES**, please give details. ______________________________

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7. Does your patient currently have visual field loss in both eyes YES ☐ NO ☐
If **YES**, please enclose copies of any reports/field charts.

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8. Has your patient suffered any form of epileptic attack within the last 5 years? YES ☐ NO ☐

8a. Has an epileptic attack occurred within the past 12 months? YES ☐ NO ☐

8b. Please give date of any epileptic attacks below:

	Awake DD	Awake MM	Awake YY	Asleep DD	Asleep MM	Asleep YY
Date of first epileptic attack						
Date of last epileptic attack						

8c. If your patient has suffered both sleep and awake epileptic attacks, please give date below of the first asleep attack after the last awake attack

Date ☐☐☐

9. Has your patient had an insertion or upper end revision of a VP shunt? YES ☐ NO ☐

Date of insertion ☐☐☐

Date of revision ☐☐☐

10. In the last 12 months, has your patient demonstrated persistent misuse of either drugs or alcohol (including recurrent binge drinking)? YES ☐ NO ☐

If **YES**, please give details (including actual drugs,blood test/urine results (if available)

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11. Please give dates of any detoxification treatment for either drugs or alcohol in the last 3 years:

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12. Are you aware of any other medical condition that may affect safe driving?. If **YES**, please give details ________________ YES ☐ NO ☐

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13. Does your patient have any significant impairment of limb function? YES ☐ NO ☐
If **YES**,please give details ________________

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14. Please give the name(s)/address of any other doctor(s)/specialist(s) involved in your patient’s treatment. ________________

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Is there an Invoice to follow? Yes ☐ No ☐ Is there a VAT Invoice to follow? Yes ☐ No ☐

Signature: ______________________

Name: ______________________

Date: ______________________

Phone No: ______________________

ADDRESS STAMP

GMC No: ______________________ **Date of renewal**: ☐☐☐

Please enter the payee details i.e. the name of the person/organisation that the fee is made payable to

Name (in capitals) ______________________