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

AUGUST 2010 Incorporating September 2010 amendments

The standards are reviewed every six months, following updated advice from the Secretary of State's Honorary Medical Advisory Panels. The next revision is scheduled for Spring 2011.

9/10

An executive agency of the Department for Transport

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SUMMARY OF AMENDMENTS updated August 2010 (unless otherwise stated)

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Page 2 DVLA website link for the At a Glance Guide has been amended in the first paragraph.

THE LEGAL BASIS FOR THE MEDICAL STANDARDS – Wording has been revised highlighting - "The 2nd DLD was amended by Directive 2009/112/EC with effect from 15.9.09 and these amendments came into force on 15.9.2010". **(updated September 2010)**

Page 3 AGE LIMITS – Group 2 – Additional information has been added to this section regarding Certificate of Professional Competence.

CHAPTER 1 NEUROLOGICAL DISORDERS

Page 9 CEREBOVASCULAR DISEASE – Group 2 Entitlement – Second paragraph has been added to this section.

Page 10 PITUITARY TUMOUR - TRANSPHENOIDAL SURGERY/OTHER TREATMENT Group 1 Entitlement – Wording has been revised.

BENIGN SUPRATENTORIAL TUMOURS - Group 1 Entitlement - Information under condition and entitlement has been revised.

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

Revised August/September 2010

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 and NHSpurchasing.co.uk. 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.**

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 medical advisers at the Drivers Medical Group, 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. An example is insulin treated diabetes. 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 Public Carriage Office 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 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 PUB 109) and the guidance leaflet ***Medical Exemption from Compulsory Seat Belt Wearing*** via on-line ordering – www.orderline.dh.gov.uk or by phoning 0300 123 1002. The certificates come in booklets of five. Further enquiries should be made to: Department for Transport, Road Safety Division 1, Zone 2/15, Great Minster House, 76 Marsham Street, London SW1P 4DR; Tel: 020 7944 2046; Email: terry.deere@dft.gsi.gov.uk

- **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 DVLA is legally responsible for deciding if a person is medically unfit to drive. They need to know when driving licence holders have a condition, which may, now or in the future, affect their safety as a driver.

2. Therefore, where patients have such conditions, you should:

   - Make sure that the patients understand that the condition may impair their ability to drive. If a patient is incapable of understanding this advice, for example because of dementia, you should inform the DVLA immediately.
   - Explain to patients that they have a legal duty to inform the DVLA about the condition.

3. If the patients refuse to accept the diagnosis or the effect of the condition on their ability to drive, you can suggest that the patients seek a second medical opinion, and make appropriate arrangements for the patients to do so. You should advise patients not to drive until the second opinion has been obtained.

4. If patients continue to drive when they are not fit to do so, you should make every reasonable effort to persuade them to stop. This may include telling their next of kin, if they agree you may do so.

5. If you do not manage to persuade patients to stop driving, or you are given or find evidence that a patient is continuing to drive contrary to advice, you should disclose relevant medical information immediately, in confidence, to the medical adviser at DVLA (details can be found on page 5).

6. Before giving information to the DVLA you should inform the patient of your decision to do so. Once the DVLA has been informed, you should also write to the patient, to confirm that a disclosure has been made."

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- **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, the medical adviser at 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. **The Secretary of State in the person of DVLA's medical advisers alone can make this decision.**

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 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 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

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
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/SOLITARY FIT	6 months off driving from the date of the seizure unless there are clinical factors or investigation results which suggest an unacceptably high risk of a further seizure, ie. 20% or greater per annum.	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.
For Group 2 licensing. 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.		
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.	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.**

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, SAH, can often be identified by the history, examination and the appropriate referral made. The relevant DVLA guidelines will then apply.

50% of all cases have a cardiac 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
1. Simple Faint 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 3 below**).	No driving restrictions. DVLA need not be notified.	NB Cough Syncope see Chapter 7 No driving restrictions DVLA need not be notified
2. Loss of consciousness/ loss of or altered awareness likely to be unexplained syncope and **low risk** of recurrence. These have no clinical evidence of structural heart disease and a normal ECG.	Can drive 4 weeks after the event.	NB Cough Syncope see Chapter 7 Can drive 3 months after the event.
3. Loss of consciousness/ loss of or altered awareness likely to be unexplained syncope and **high risk** of recurrence 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**	Can drive 4 weeks after the event if the cause has been identified and treated. If no cause identified, licence refused/revoked for 6 months.	NB Cough Syncope see Chapter 7 Can drive 3 months after the event if the cause has been identified and treated. If no cause identified, then licence refused/revoked for one year.

See Appendix at end of this Chapter

NEUROLOGICAL DISORDERS	GROUP 1 ENTITLEMENT ODL – CAR, M/CYCLE	GROUP 2 ENTITLEMENT VOC – LGV/PCV
4. Presumed 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. The seizure markers act as indicators and are not absolutes: - 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 a solitary 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. 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

NEUROLOGICAL DISORDERS	GROUP 1 ENTITLEMENT ODL – CAR, M/CYCLE	GROUP 2 ENTITLEMENT VOC – LGV/PCV
NARCOLEPSY/CATAPLEXY	**Cease driving on diagnosis**. Driving will be permitted when satisfactory control of symptoms achieved, then 1, 2 or 3-year licence with regular medical review. Till 70 licence restored after 7 years of satisfactory control.	Generally considered unfit permanently, but if a long period of control has been established licensing **may** be considered on an individual basis.
CHRONIC NEUROLOGICAL DISORDERS e.g. Parkinson's disease, multiple sclerosis, muscle and movement disorders including motor neurone disease, likely to 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).
LIABILITY TO SUDDEN ATTACKS OF UNPROVOKED OR UNPRECIPITATED DISABLING GIDDINESS e.g. Ménière's disease	**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.

See Appendix at end of this Chapter

NEUROLOGICAL DISORDERS	GROUP 1 ENTITLEMENT ODL - CAR, M/CYCLE	GROUP 2 ENTITLEMENT VOC – LGV/PCV
CEREBROVASCULAR DISEASE: including stroke due to occlusive vascular disease, spontaneous intracerebral haemorrhage, TIA, amaurosis fugax and intracranial venous thrombosis.	**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). A driver experiencing multiple TIAs over a short period may require 3 months free from further attacks before resuming driving and should notify DVLA. Epileptic attacks 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. Seizures occurring at the time of intracranial venous thrombosis require 6 months free from attacks before resuming driving.	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 will also be subject to satisfactory medical reports including exercise ECG testing. Where there is imaging evidence of essentially normal carotid arteries Group 2 licensing may be allowed without the need for functional cardiac assessment.
ACUTE ENCEPHALITIC ILLNESSES AND MENINGITIS	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.**

See Appendix at end of this Chapter

NEUROLOGICAL DISORDERS	GROUP 1 ENTITLEMENT ODL - CAR, M/CYCLE	GROUP 2 ENTITLEMENT VOC – LGV/PCV
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.
BENIGN SUPRATENTORIAL TUMOUR e.g. WHO Grade 1 meningioma TREATMENT WITH SURGERY BY CRANIOTOMY WITH OR WITHOUT RADIOTHERAPY	Generally, requires 6 months off driving if no relevant history of seizure(s). 1 year off driving 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.
WHO GRADE II MENINGIOMA TREATED WITH SURGERY BY CRANIOTOMY WITH OR WITHOUT RADIOTHERAPY	Requires 1 year off driving, also need to be 12 months seizure free.	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.
Asymptomatic incidental meningioma, 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
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) and gliomas		
Supratentorial		
Grades 1 and II gliomas	1 year off driving, from time of completion of the primary treatment.	Permanent refusal or revocation.
WHO Grade III meningioma	2 years off driving from time of completion of primary treatment.	Permanent refusal or revocation.
Grades III and IV gliomas and metastatic deposit(s).	At least 2 years off driving from time of completion of primary treatment.	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 Secondary Deposits	Normally, a period of 2 years off driving is required following treatment.	Permanent refusal or revocation.
Solitary metastatic deposit	If totally excised, can be considered for licensing 1 year after primary treatment if free from recurrence and no evidence of secondary spread elsewhere in the body.	Permanent refusal or revocation.
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
SIGNIFICANT HEAD 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.
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. DUE TO INTRACRANIAL ANEURYSM		
(a) SURGERY CRANIOTOMY Anterior or posterior cerebral aneurysm		
With NO deficit	Driving permitted when clinically recovered from craniotomy	1 year off driving
With deficit	6 months off driving. Till 70 licence restored if no complications	Refusal or revocation. Specialist assessment to determine when driving may start: risk of seizure must have fallen to no greater than 2% per annum with no debarring residual impairment likely to affect safe driving.
Middle Cerebral Aneurysm		
With NO deficit	6 months off driving after craniotomy	18 months – 2 years off driving after craniotomy.
With deficit	1 year off driving after craniotomy.	Refusal or revocation. Specialist assessment to determine when driving may start: risk of seizure must have fallen to no greater than 2% per annum with no debarring residual impairment likely to affect safe driving.

See Appendix at end of this Chapter

NEUROSURGICAL DISORDERS	GROUP 1 ENTITLEMENT ODL - CAR, M/CYCLE	GROUP 2 ENTITLEMENT VOC – LGV/PCV
(b) OTHER TREATMENT e.g. Embolisation and all other non-craniotomy procedures including GDC coils.	**Cease driving until** clinically recovered.	Refusal or revocation. There must be reliable angiographic evidence of complete ablation of aneurysm before re-licensing can be considered. The risk of seizure must have fallen to no greater than 2% per annum with no debarring residual impairment likely to affect safe driving.
(c) NO TREATMENT i.e. Aneurysm responsible for SAH but no intervention.	6 months off driving after diagnosis then Till 70 licence if no complications.	Refusal or revocation.
(d) TRULY INCIDENTAL FINDINGS OF INTRACRANIAL ANEURYSM (aneurysm has not been responsible for subarachnoid haemorrhage)		
NO TREATMENT	Retain Till 70 licence.	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	Resume driving on recovery.	1 year off driving.

See Appendix at end of this Chapter

NEUROLOGICAL DISORDERS	GROUP 1 ENTITLEMENT ODL - CAR, M/CYCLE	GROUP 2 ENTITLEMENT VOC – LGV/PCV
ARTERIOVENOUS MALFORMATION 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
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.
CAVERNOUS MALFORMATION		
Supratentorial		
a) Incidental	No restriction	No restriction
b) Seizure, no surgical treatment	Epilepsy Regulations	Epilepsy Regulations
c) Haemorrhage and/or focal neurological deficit, no surgical treatment	Can drive when there is no debarring residual impairment likely to affect safe driving.	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	Revoked/refuse until 10 years post-obliteration of the lesion and Epilepsy Regulations apply.
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.	Can drive when there is no debarring residual impairment likely to affect safe driving.
c) Treated by surgical excision (craniotomy).	As above.	As above.

NB.

- Radio-surgery for a cavernous malformation equates to an untreated lesion for the time being.
- 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
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.	Individual assessment.
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.	Individual assessment.
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

The Motor Vehicles (Driving Licences) Regulations 1999, prescribe epilepsy as a relevant disability for the purposes of Section 92(2) of the Road Traffic Act 1988.

This means that:

1) A person who has suffered an epileptic attack whilst **awake** must refrain from driving for at least **one** year from the date of the attack before a driving licence may be issued.

2) A person who has suffered an attack whilst **asleep** must also refrain from driving for at least **one** year from the date of the attack. However, if they have had an attack whilst asleep more than three years previously and have had no attacks whilst awake since that original attack whilst asleep, then they may be licensed even though attacks whilst asleep may continue to occur. If an attack whilst awake subsequently occurs, then the formal epilepsy regulations apply and require at least **one** year off driving from the date of the attack.

AND in both cases

3) i) so far as practicable, the person complies with advised treatment and check-ups for epilepsy, and
ii) the driving of a vehicle by such a person should not be likely to cause danger to the public.

GROUP 2

During the period of **10 years** immediately preceding the date when the licence is granted the applicant/licence holder should:

1) be free from **any** epileptic attack

AND

2) have not taken medication to treat epilepsy

AND

3) not otherwise be a source of danger whilst driving.

In addition **"The liability to seizures arising from a cause other than epilepsy"** is a prescribed disability. In addition, someone with a structural intracranial lesion who has an increased risk of seizures will not be able to drive vehicles of this group until the risk of a seizure has fallen to no greater than 2% per annum, the level recommended by the Panel, which permits compliance with the regulations.

GUIDANCE FOR CLINICIANS ADVISING PATIENTS TO SURRENDER THEIR DRIVING LICENCE IN THE CASE OF BREAK-THROUGH SEIZURES IN THOSE WITH ESTABLISHED EPILEPSY:

In the event of a seizure, the patient must be advised not to drive unless they are able to meet the conditions of the asleep concessions. The patient should also be advised to notify the DVLA. In exceptional cases (e.g. seizure secondary to prescribing error), the clinician is advised to discuss the circumstances individually with the Medical Adviser at the DVLA before advising the patient on the appropriate licensing procedure.

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. The current Epilepsy Regulations require a period of at least one year free of any manifestation of epileptic seizure or attacks whilst awake from the date of the last attack; special consideration is given where attacks have occurred only whilst asleep.

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, which is not associated with any damage on CT scanning, nor with post traumatic amnesia of longer than 30 minutes
- 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
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. • 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
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
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
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 page 21 apply 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 page 21 apply 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
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
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.
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
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
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'.

CHAPTER 3
DIABETES MELLITUS

DIABETES MELLITUS	**GROUP 1 ENTITLEMENT ODL - CAR, M/CYCLE**	**GROUP 2 ENTITLEMENT VOC – LGV/PCV**
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 recognise warning symptoms of hypoglycaemia and meet required visual standards. 1, 2 or 3 year licence.	New applicants on insulin or existing drivers are barred in law from driving LGV or PCV vehicles from 1/4/91. Drivers licensed before 1/4/91 on insulin are dealt with individually and licensed subject to satisfactory annual Consultant assessment. Regulation changes in April 2001 allow "exceptional case" drivers to apply for or renew their entitlement to C1/C1E to drive small lorries with or without a trailer subject to meeting all "Qualifying Conditions". **(See Appendix to this Chapter for full details)**
TEMPORARY INSULIN TREATMENT e.g. gestational diabetes, post-myocardial infarction, participants in oral/inhaled insulin trials.	Need not notify DVLA but should stop driving if experiencing disabling hypoglycaemia. Notify DVLA if treatment continues for more than 3 months.	Legal bar to holding a licence while insulin treated. May reapply when insulin treatment is discontinued.
MANAGED BY TABLETS **See Appendix to this Chapter for** INF188/2	If all the requirements set out in the attached information on INF188/2 are met, DVLA does not require notification. This 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. For drivers taking medication likely to cause hypoglycaemia such as a sulphonylurea, it may be appropriate to monitor blood glucose regularly and at times relevant to driving to enable the detection of hypoglycaemia.	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. If becomes insulin treated will be refusal or revocation. Drivers are advised to monitor their blood glucose regularly and at times relevant to driving, particularly if taking medication likely to cause hypoglycaemia such as a sulphonylurea.
MANAGED BY EXENATIDE OR GLIPTINS IN COMBINATION WITH A SULPHONYLUREA	See above for managed by tablets	Individual assessment Further information on this topic can be found on the DVLA website: http://www.dft.gov.uk/dvla/medical/Treatment%20with%20Exenatide%20Liraglutide%20or%20Gliptins.aspx
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.

See Appendix at end of this Chapter

DIABETIC COMPLICATIONS	GROUP 1 ENTITLEMENT	GROUP 2 ENTITLEMENT
Frequent hypoglycaemic episodes likely to impair driving	**Cease driving until** satisfactory control re-established, with consultant/GP report.	See above for **insulin treated**. Refusal or revocation.
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 above for **insulin treated**. Refusal or revocation.
Eyesight complications (affecting visual acuity or fields)	See Section: **Visual Disorders**	See above 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 knowledge of their specific circumstances.

A Guide for Drivers with Insulin Treated Diabetes who wish to apply for C1/C1E Entitlement

Drivers may apply for or renew their entitlement to categories **C1/C1+E** to drive small lorries with or without a trailer.

They may also be eligible to renew category C1E, to drive small lorries with a combined weight of 12 tonnes, if they have passed category CE, although this does not apply if they have previously held CE (102). **They will not be entitled by law to hold Category D1 (Minibuses**

Qualifying Conditions you must meet

- They must have had no hypoglycaemic attacks requiring assistance whilst driving within the previous 12 months.
- They will not be able to apply for category C1 or C1E entitlement until their condition has been stable for a period of at least one month.
- They must regularly monitor their condition by checking their blood glucose levels at least twice daily and at times relevant to driving. We advise the use of a memory chip meters for such monitoring
- They must arrange to be examined every 12 months by a hospital consultant, who specialises in diabetes. At the examination the consultant will require sight of their blood glucose records for the last 3 months.
- They must have no other condition, which would render them a danger when driving C1 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.

INF188/2

Information for drivers of cars or motorcycles with Diabetes treated by tablets, 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 treaded 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.

What you need to tell us about

By law you must tell us if any of the following apply:

- 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 light at 20.5 metres (67 feet) or 20 metres (65 feet) where narrower characters 50mm wide are displayed.
- 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 noted on your driving licence.

HYPOGLYCAEMIA

The risk of hypoglycaemia (low blood sugar) is the main hazard 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 continue to drive even though they are experiencing warning signs of hypoglycaemia. If you experience warning signs of hypoglycaemia while driving you must always stop as soon as safely possible – **do not ignore the warning signs**.

You must inform DVLA if:

- you suffer more than one episode of disabling hypoglycaemia (low blood sugar) within 12 months, or if you or your carer feels you are at high risk of developing disabling hypoglycaemia.
- you develop impaired awareness of hypoglycaemia. (difficulty in recognising the warning symptoms of low blood sugar)
- you suffer disabling hypoglycaemia while driving.
- an existing medical condition gets worse or you develop any other condition that may affect you driving safely.

In the interests of road safety you must be sure that you can safely control a motor 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 DIAB1 medical questionnaire about diabetes.

You can download this from www.direct.gov.uk/driverhealth

Phone us on: 0300 790 6806

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

E-mail: eftd@dvla.gsi.gov.uk

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 Feb 09

DIABINF

Information for drivers of cars or motorcycles with Insulin Treated Diabetes

Please keep for further reference

Drivers who have any form of diabetes treated with any insulin preparation must inform DVLA

EYESIGHT

All drivers are required by law to read, in good daylight, a car number plate from a distance of 20 metres or 20.5 metres where the old style number plate is used.

You must inform DVLA

- If you are unable to meet the number plate requirement.
- Of any problems that affect your field of vision.
- Of any conditions that affect both eyes or the remaining eye if you have sight in one eye only
- If you have had laser treatment to both eyes for retinopathy, or to the remaining eye if monocular.

HYPOGLYCAEMIA

The risk of hypoglycaemia (low blood sugar) is the main hazard to safe driving. This may endanger your own life as well as that of other road users. Many of the accidents caused by hypoglycaemia are because drivers continue to drive even though they are experiencing warning signs of hypoglycaemia. If you experience warning signs of hypoglycaemia whilst driving you must always stop as soon as safely possible – **do not ignore the warning signs**.

You must inform DVLA if:

- you suffer more than one episode of disabling hypoglycaemia (low blood sugar) within 12 months, or if you or your carer feels you are at high risk of developing disabling hypoglycaemia.
- you develop impaired awareness of hypoglycaemia. (difficulty in recognising the warning symptoms of low blood sugar)
- you suffer disabling hypoglycaemia while driving.
- an existing medical condition gets worse or you develop any other condition that may affect you driving safely.

LIMB PROBLEMS

Limb problems/amputations are unlikely to prevent driving. They may be overcome by either restricting driving to certain types of vehicles e.g. those with automatic transmission, or by adaptations such as hand operated accelerator/brake.

You must inform DVLA

- If you develop problems with either the nerves or the circulation in your legs which prevent safe use of the foot pedals.

Drivers with insulin treated diabetes are advised to take the following precautions:

- Do not drive if you feel hypoglycaemic or if your blood glucose is less than 4.0 mmol/l.
- If hypoglycaemia develops while driving stop the vehicle as soon as possible in a safe location, switch off the engine, remove the keys from the ignition and move from the drivers seat.
- Do not resume driving until 45 minutes after blood glucose has returned to normal. It takes up to 45 minutes for the brain to fully recover.
- Always keep an emergency supply of fast-acting carbohydrate such as glucose tablets or sweets within easy reach in the vehicle.
- Carry your glucose meter and blood glucose strips with you. Check blood glucose before driving (even on short journeys) and test regularly (every 2 hours) on long journeys. If blood glucose is 5.0mmol/l or less, take a snack before driving.
- Carry personal identification indicating 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.
- Take regular meals, snacks and rest periods on long journeys. Always avoid alcohol.

CONTACT US

Web site: www.direct.gov.uk/driverhealth

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

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

E-mail: eftd@dvla.gsi.gov.uk

Rev: Aug 08

CHAPTER 4

PSYCHIATRIC DISORDERS

PSYCHIATRIC DISORDERS	GROUP 1 ENTITLEMENT ODL - CAR, M/CYCLE	GROUP 2 ENTITLEMENT VOC – LGV/PCV
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 dependency 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 dependency 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
HYPOMANIA/MANIA NB: For cases, which also involve persistent misuse of or dependency 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 dependency 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.

See Appendix at end of this Chapter

DISORDER	GROUP 1 ENTITLEMENT ODL - CAR, M/CYCLE	GROUP 2 ENTITLEMENT VOC – LGV/PCV
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.
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.
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 dependency 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

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.

CHAPTER 5

DRUG AND ALCOHOL MISUSE AND DEPENDENCY

ALCOHOL PROBLEMS	GROUP 1 ENTITLEMENT ODL - CAR, M/CYCLE	GROUP 2 ENTITLEMENT VOC – LGV/PCV
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 dependency". 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 DEPENDENCY "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. Reference to ICD10 **F10.2 – F10.7 inclusive** is relevant	**ALCOHOL DEPENDENCY** Alcohol dependency, 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. **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. See also under **"Alcohol related seizures"**	**ALCOHOL DEPENDENCY** Vocational licensing will not be granted where there is a history of alcohol dependency 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. See also under **"Alcohol related seizures"**

ALCOHOL PROBLEMS	GROUP 1 ENTITLEMENT ODL - CAR, M/CYCLE	GROUP 2 ENTITLEMENT VOC – LGV/PCV
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 dependency. 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 dependency 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/dependency and/or unexplained abnormal blood test analysis will have the application refused.

DRUG MISUSE AND DEPENDENCY Reference to **ICD**10 **F10.1-F10.7** inclusive is relevant.	**GROUP 1 ENTITLEMENT ODL - CAR, M/CYCLE**	**GROUP 2 ENTITLEMENT VOC – LGV/PCV**
Cannabis Amphetamines (*note: Metamphetamine below)* Ecstasy Ketamine & other psychoactive substances, including LSD and Hallucinogens	Persistent use of or dependency 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 dependency 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 Metamphetamine	Persistent use of, or dependency 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 dependency 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/dependency for licensing purposes. The prescribed use of these drugs at therapeutic doses (BNF), without evidence of impairment, does not amount to misuse/dependency for licensing purposes (although clinically dependence may exist).	Persistent misuse of, or dependency 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 dependency 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 dependency – including misuse with alcohol – is incompatible with licensing fitness

DRUG MISUSE AND DEPENDENCY Reference to **ICD**10 **F10.1-F10.7** inclusive is relevant.	**GROUP 1 ENTITLEMENT** **ODL - CAR, M/CYCLE**	**GROUP 2 ENTITLEMENT** **VOC – LGV/PCV**
Seizure(s) associated with drug misuse/dependency Seizures associated with drug misuse/dependency are not considered provoked for licensing purposes.	Following a **solitary** seizure associated with drug misuse or dependency, 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 dependency, 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 dependency. Independent medical assessment with urine analysis and consultant reports will normally be necessary.	Following a **solitary** seizure associated with drug misuse or dependency, 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 dependency 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 light (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.

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**
ACUITY	Must be able to meet the above prescribed eyesight requirement.	New applicants are barred in law if the visual acuity, using corrective lenses if necessary, is worse than 6/9 in the better eye or 6/12 in the other eye. Also, the uncorrected acuity in each eye MUST be at least 3/60. * / *** Grandfather Rights 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 requirement. In the presence of cataract, glare may prevent the ability to meet the number plate requirement, even with apparently appropriate acuities.	Must be able to meet the above prescribed acuity requirement. In the presence of cataract, glare may prevent 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 but may drive when clinically advised that driver has adapted to the disability **and** the prescribed eyesight standard in the remaining eye can be satisfied **and** there is a normal monocular visual field in the remaining eye, i.e. there is no area of defect which is caused by pathology.	**Complete** loss of vision in one eye or corrected acuity of less than 3/60 in one eye. Applicants are barred in law from holding a Group 2 licence. **/*** Grandfather Rights below.
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 end of Chapter for full definition and for conditions to be met for consideration as an exceptional case on an individual basis)	Normal binocular field of vision is required, i.e., any area of defect in a single eye is totally compensated for by the field of the other eye.

See Appendix at end of this Chapter

*** 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 and the visual field requirement for the remaining eye.**

VISUAL DISORDERS	GROUP 1 ENTITLEMENT ODL - CAR, M/CYCLE	GROUP 2 ENTITLEMENT VOC – LGV/PCV
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

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. 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.

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.

Exceptional cases
For 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
- caused by an isolated event or a non-progressive condition **and**
- there must be no other condition or pathology present which is regarded as progressive and likely to be affecting the visual fields.

In order to meet the requirements of European law, DVLA will, in addition, require:

- 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 new 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: http://www.dft.gov.uk/dvla/medical.aspx

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.

CHAPTER 7

RENAL DISORDERS

RENAL DISORDERS	GROUP 1 ENTITLEMENT ODL - CAR, M/CYCLE	GROUP 2 ENTITLEMENT VOC – LGV/PCV
CHRONIC RENAL FAILURE CAPD (Continuous ambulatory peritoneal dialysis) Haemodialysis	Issue of licence dependent on medical enquiries. No restriction on holding a Till 70 licence unless subject to 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 Medical Unit.
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 and SLEEP DISORDERS

RESPIRATORY and SLEEP DISORDERS	GROUP 1 ENTITLEMENT ODL - CAR, M/CYCLE	GROUP 2 ENTITLEMENT VOC – LGV/PCV
SLEEP DISORDERS Including Obstructive Sleep Apnoea syndrome causing excessive daytime / awake time sleepiness 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.
COUGH SYNCOPE	**Driving must cease until** liability to attacks has been successfully controlled, confirmed by medical opinion.	**Driving must cease.** If there is any chronic respiratory condition, including smoking will need to be free of syncope/pre-syncope for 5 years. Individuals identified as having asystole in response to coughing can be considered once a pacemaker has been implanted.
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
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.
BRAIN TUMOURS	Please refer to the appropriate section of Chapter 1	Please refer to the appropriate section of Chapter 1
LUNG CANCER	Please refer to the appropriate section of Chapter 7	Please refer to the appropriate section of Chapter 7
OTHER CANCERS	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
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.

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
DISABLED DRIVERS' ASSESSMENT CENTRES

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

BIRMINGHAM: (Incorporating a satellite centre at Cannock, Staffordshire). 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: alexbarr@btconnect.com
BRISTOL: (Incorporating a satellite centres at Sparkford, Somerset & Cheltenham, Glos) Tel: 0117 965 9353 Fax: 0117 965 3652 **I D P W T**	Mobility 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@wddac.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 courses	Queen Elizabeth's Foundation Mobility Centre, Damson Way, Fountain Drive, Carshalton, Surrey, SM5 4NR. Email: info@mobility-qe.org Website: www.qefd.org/mobilitycentre/
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, SMART Centre, 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: 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 Canterbury and Herne Bay) Tel: 01622 795719 Fax: 01622 795720 **I D P**	South East DriveAbility, Cobtree Ward, Preston Hall Hospital London Road, Aylesford, Kent, ME20 7NJ Email: wk-pct.sedriveability@nhs.net
NEWCASTLE UPON TYNE: (Incorporating satellite centre at Penrith, Cumbria) Tel: 0191 287 5090 Fax: **I D P T**	North East Drive Mobility 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/?p=services&s=nap&c=SpecialistTeams
OXFORD: Tel: 0845 337 1540 Fax : 0121 333 71540 **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 a satellite centre at Salisbury, Wilts)

Tel: 023 8051 2222

I D P T

Wessex DriveAbility,
Unit 211,
Solent Business Centre.
Millbrook Road West,
Southampton SO15 0HW.
Email: enquiries@wessexdriveability.org.uk
Website: www.wessexdriveability.org.uk

THETFORD
(Incorporating a satellite centre at Coggeshall, 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: mail@eastangliandriveability.org.uk
Website: www.eastangliandriveability.org.uk

TRURO
(Incorporating Exeter, Plymouth and Holsworthy, Devon Outreach Centres).

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: enquiries@mobility@rcht.cornwall.nhs.uk
Website: http://www.cornwallmobilitycentre.co.uk

WELWYN GARDEN CITY

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.co.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

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