Driver & Vehicle Licensing Agency

Confidential medical information

DR1 ONLINE
Rev Sept 14

PART A: ABOUT YOU

Please answer the questions on this form in **BLOCK CAPITAL** letters using **BLACK INK**

Title: (Mr, Mrs, Miss, Other?) Surname: Date of Birth:

First Name(s): Driver No: *(if known)*

Address: Telephone Number(s):

Home

Mobile

Postcode Email

PART B: ABOUT YOUR GP AND YOUR CONSULTANT

GP's Name and Address

Dr:

Postcode:

TEL No: *(Including dialling code)*

Consultants Name and Address

Title:

Department:

Postcode:

TEL No: *(Including dialling code)*

Date last seen by GP (For this condition)

Date last seen by Consultant (For this condition)

If you have more than one consultant, please give their name, department and address on a separate sheet.

GP email address *(if known)*

Consultants email address *(if known)*

Hospital number *(if known)*

PART C: Please give details of other clinics you are attending below

Name of clinic & Department	Reason for attendance	Date last seen

Questionnaire to assess your medical fitness to drive

If you are unsure of the answers we advise you to discuss this form with your doctor

Please answer all questions and provide dates

1. Within the last 3 years have you:-

		Yes	No	Day	Month	Year
a)	been dependent on or misused alcohol					
b)	had an accident/injury, including a road traffic accident, as a result of your alcohol intake?					
	If Yes, please give date					
c)	had a problem with your home/family or work life due to your alcohol intake?					
d)	undergone an alcohol detoxification programme?					
e)	had alcohol withdrawal symptoms?					
f)	had or do you have liver damage?					
g)	required hospital treatment for alcohol related illness?					
h)	been advised by a doctor or counsellor to reduce your alcohol intake?					
i)	had memory loss after drinking					

2. Have you had any alcohol related fits or seizures? Yes ☐ No ☐

If Yes, please provide dates of attacks below

	Awake			Sleep		
	Day	Month	Year	Day	Month	Year
Date of first seizure						
Date of last seizure						

NAME:	DOB:	REF:
DRIVER NUMBER:		

3a. How often do you have a drink containing alcohol? _____

b. How many units of alcohol do you drink on a typical day when you are drinking? _____

c. How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year? _____

d. When did you last have a drink?

Day	Month	Year

e. How much alcohol was consumed on the last occasion? _____

4. In the last 3 years have you seen a hospital doctor or GP about any alcohol related problems?

Yes	No

If Yes, please provide the following :-

Name of Doctor : _____

Clinic/Hospital Address : _____

Reason for attending : _____

Date last seen : _____

5a. In the last 3 years have you used cannabis?
If Yes, please supply details below and date last used

Yes	No

How much : _____ How often: _____

Month	Year

5b. Please fill in the box(es) below if you have misused any of the illicit street drugs or substances in the last 3 years and date last taken.

	Yes	No	How much	How often	Month	Year
Lsd/Ecstasy/Amphetamine:						
Benzodiazepines:						
Cocaine/Crack Cocaine:						
Heroin:						

5c. Any other drugs taken : Please specify _____

6. Are you on a treatment programme for previous drug dependence e.g Methadone, Buprenorphine?

Yes	No	Month	Year

If Yes, please give date started. _____

7. Please list all tablets/drugs or prescribed medication that you are taking at present

Name of tablet/drug or prescribed medication	Dosage (the amount you take)

8. Do you currently have any injury, illness or medical condition that could affect your driving?

Yes	No

If Yes, please explain _____

Driver Declaration

I declare that I have checked the details given and that to the best of my knowledge and belief they are correct

Signature _____ Date | | | |

Driver & Vehicle Licensing Agency

Applicants declaration

You **must** fill in this section and must **not** alter it in any way. Please read the following information carefully and sign to confirm the statements below/

Important information about fitness to drive

- As part of the investigation into your fitness to drive, we (DVLA) may require you to have a medical examination and/or some form of practical assessment. If we do, the individuals involved in these will need your background medical details to carry out an appropriate assessment.
- These individuals may include doctors, orthoptists at eye clinics or paramedical staff at a driving assessment centre. We will only release information relevant to the medical assessment of your fitness.
- Also, where the circumstances of your case appear to suggest the need for this, the relevant medical information may need to be considered by one or more of the members of the Secretary of State's Honorary Medical Advisory Panels. The membership of these Panels conforms strictly to the principle of confidentiality.

All data held by DVLA is used for internal evaluation of the quality of our services.

This section must NOT be altered in any way.

Declaration

I authorise my Doctor(s) and Specialist(s) to release reports/medical information about my condition relevant to my fitness to drive, to the Secretary of State's medical adviser.

I understand that the Secretary of State may disclose such relevant medical information as is necessary to the investigation of my fitness to drive to doctors, orthoptists, paramedical staff and panel members.

I declare that I have checked the details I have given on the enclosed questionnaire and that, to the best of my knowledge and belief they are correct.

"I understand that it is a criminal offence if I make a false declaration to obtain a driving licence and can lead to prosecution."

Name: _____

Signature: _____ Date: _____

I authorise the Secretary of State to :

Inform my Doctor(s) of the outcome of my case **Yes** ☐ **No** ☐

Release my medical information, and any other relevant information, to my doctor(s) by postal or electronic (fax or email) channels **Yes** ☐ **No** ☐

If you would like to be contacted about your application by email or Text message (SMS), please tick the appropriate boxes (below). If not, DVLA will continue to contact you by post.

I authorise a representative of the Secretary of State to contact me via Email or SMS Text in relation to this application (Please Tick): Email ☐ **Yes** ☐ **No** **SMS (Text)** ☐ **Yes** ☐ **No**

NAME:	DOB:	REF:
DRIVER NUMBER:		

Driver & Vehicle Licensing Agency

Note: please fill in and return all pages (1-5) of this medical questionnaire and consent/declaration. If you do not give us all the information we need including the full name, address and telephone number of your GP/Consultant then there will be a delay with your case.

Please use the contact details below to return your filled in medical questionnaire to the Drivers Medical Group.

By Post

Drivers Medical Group
DVLA
Swansea
SA99 1DF

By fax

0300 083 0083

Please keep this page (6) for future reference.