Driver & Vehicle Licensing Agency

Confidential medical information

DG1V 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: Postcode

Telephone Number(s):
Home
Mobile

Email

PART B: ABOUT YOUR GP AND YOUR CONSULTANT

GP's Name and Address

Dr:

Postcode:

Consultants Name and Address

Title:

Department:

Postcode:

TEL No: *(Including dialling code)*

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)*

NHS 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 need assistance completing this form please speak to your doctor

1. In the past 3 years have you been on a drug treatment programme? e.g. buprenorphine, methadone, naltrexone for opioid drug dependence

Yes ☐ No ☐

If Yes, please give the date treatment started, and ended (if applicable)

Start date		**End date**	
Month	Year	Month	Year

2. In the past 3 years have you been on a drug treatment programme for any other drug problems? e.g. cannabis

Yes ☐ No ☐

If Yes, please give the name of the drug(s) _____

Please give the date treatment started and ended (if applicable)

Start date		**End date**	
Month	Year	Month	Year

3. If Yes to either question 1 or 2, please give the name and address of your doctor/consultant at the clinic.

Name _____

Address _____

_____

_____

	Month	Year
Date last seen		

4. Within the last 3 years have you used any of the following:
(Please indicate which drugs and provide the requested information)

		Yes	Date first used Month/Year	Date last used Month/Year	How much? (quantity used)	How often? (per week/month)
a)	Heroin?					
b)	Morphine?					
	If Yes, is the morphine prescribed?				Yes ☐	No ☐
c)	Non prescribed methadone or buprenorphine ?					
d)	Cocaine/Crack Cocaine?					
e)	Methamphetamine/ Crystal Meth?					
f)	Benzodiazapines? (e.g.Diazepam/ Temazepam)					
	If Yes, are the benzodiazapines prescribed?				Yes ☐	No ☐

		Yes	Date first used Month/Year	Date last used Month/Year	How much? (quantity used)	How often? (per week/month)
g)	Cannabis?					
h)	Amphetamine?					
i)	Ecstasy (MDMA)?					
j)	LSD?					
k)	Ketamine?					
l)	Other illicit/street drugs?					
	If Yes, please give name of drug(s)					
m)	Legal or illegal highs?					
	If Yes, please give name of drug(s)					
n)	Solvents?					
	If Yes, please give name of drug(s)					

5. Within the last 3 years have you had an accident/injury, including a road traffic accident, as a result of your drug misuse? Yes ☐ No ☐

6. Within the last 3 years have you had a problem with your family/work or home life due to your drug misuse? Yes ☐ No ☐

7. Have you had any medical conditions caused by drug misuse? Yes ☐ No ☐

8. Have you ever had any fits, seizures or blackouts? Yes ☐ No ☐

   a) Please give the date of the most recent episode. Date ☐☐☐

   If Yes, please give the name and address of the doctor we should contact for further information.

   Name _____

   Address _____

   _____

   _____

   Month Year

   Date last seen ☐☐

9. In the last 3 years have you regularly misused or been dependent on alcohol? Yes ☐ No ☐

   If Yes, please give the name and address of the doctor we should contact for further information.

   Name _____

   Address _____

   _____

   _____

   Month Year

   Date last seen ☐☐

10. In the last 3 years have you had any mental health problems? Yes ☐ No ☐

If Yes, please give the name and address of the doctor we should contact for further information.

Name _____

Address _____

_____

_____

Date last seen	Month	Year

Driver declaration: I declare that I have checked the details given and that to the best of my knowledge and belief, they are correct.

Please be aware that incomplete answers may result in delays.

Signed: _____

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 (1-6) 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 (7) for future reference.