



**PART A: ABOUT YOU**

Please complete this form in **BLOCK CAPITAL** letters using **BLACK INK**

Title \_\_\_\_\_ Full name \_\_\_\_\_

Full address \_\_\_\_\_

\_\_\_\_\_

Postcode \_\_\_\_\_ Date of birth \_\_\_\_\_

NHS number \_\_\_\_\_ Driver number \_\_\_\_\_

*(If known)*

Mobile number \_\_\_\_\_ Home number \_\_\_\_\_

*(Optional)*

*(Optional)*

Email \_\_\_\_\_

*(Optional)*

**PART B: HEALTHCARE PROFESSIONAL DETAILS**

Please provide the details of the GP and Consultant you have seen for this condition

**IMPORTANT: You must provide their full name and address, or the form will be returned to you, delaying your application.**

**GP DETAILS**

Full name \_\_\_\_\_

Surgery \_\_\_\_\_

Full address \_\_\_\_\_

\_\_\_\_\_

Postcode \_\_\_\_\_ Phone number \_\_\_\_\_

Email \_\_\_\_\_

*(If known)*

Date last seen by GP for this condition \_\_\_\_\_

**CONSULTANT DETAILS**

Title \_\_\_\_\_ Full name \_\_\_\_\_

Department \_\_\_\_\_

Full hospital address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Postcode \_\_\_\_\_ Phone number \_\_\_\_\_

Email \_\_\_\_\_

*(If known)*

Date last seen by consultant for this condition \_\_\_\_\_



# Medical questionnaire – alcohol disorders

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

1. As a result of alcohol dependence, have you needed to take prescribed medication to help you stop drinking alcohol safely? (alcohol detoxification treatment) Yes  No
- a) If yes, please give the date you started the treatment. (If more than once, please give the most recent date.) Date
2. When did you last have an alcoholic drink? Date
- a) How much alcohol was consumed on the last occasion? \_\_\_\_\_
3. How often do you have a drink containing alcohol? \_\_\_\_\_
- a) How much alcohol do you drink on a typical day when you are drinking? (give amount/type, for example, units or bottle of wine) \_\_\_\_\_
- b) How often in the last year have you drunk 6 units or more on a single occasion? \_\_\_\_\_
4. Within the last 6 years have you been dependent on or regularly misused alcohol? Yes  No
5. Within the last 6 years have you had an accident/injury, including a road traffic accident, as a result of your alcohol intake? Yes  No
- a) If yes, please give the date Date
6. Within the last 6 years have you had a problem with your family/work or home life due to your alcohol intake? Yes  No
7. Within the last 6 years have you been told you have liver disease or damage? Yes  No

**DR1**

8. Within the last 6 years have you required treatment for an alcohol related illness? Yes  No

a) If yes, please give the date of most recent treatment Date

Please give details of the doctor we should contact for more information and the date of last contact (Any phone, video or face to face consultation for this condition).

Name \_\_\_\_\_ Last seen

Address \_\_\_\_\_  
\_\_\_\_\_

9. Have you had any fits, seizures or blackouts within the last 5 years? Yes  No

a) If yes, please give the date of most recent event Date

Please give details of the doctor we should contact for more information and the date of last contact (Any phone, video or face to face consultation for this condition).

Name \_\_\_\_\_ Last seen

Address \_\_\_\_\_  
\_\_\_\_\_

10. In the last 3 years have you **misused** any drugs, including prescribed drugs, over the counter medication or any other substances? Yes  No

11. In the last 3 years have you been on a treatment programme for drug misuse? Yes  No

**If yes to Q10 or Q11**, please give details of the doctor we should contact for more information and the date of last contact (Any phone, video or face to face consultation for this condition).

Name \_\_\_\_\_ Last seen

Address \_\_\_\_\_  
\_\_\_\_\_

## DR1

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

**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: \_\_\_\_\_

**The standards for driving and alcohol misuse or dependency have been reviewed and updated.**

Before you re-apply for your driving licence please ensure that you can meet the following standards:

**If there is a history of alcohol misuse** you are required to show controlled drinking at the recommended low risk limits for at least 6 months.

**If there is a history of alcohol dependency** you are required to show abstinence from alcohol for 12 months. **Abstinence means** not taking any alcohol. You must continue to abstain from alcohol should you wish to hold a driving licence.

### Recommended low risk limits

The UK Chief Medical Officers' guideline for both men and women is that to keep health risks from alcohol to a low level it is safest not to drink more than 14 units a week on a regular basis. Find out more <https://www.nhs.uk/conditions/Alcohol-misuse/Pages/Introduction.aspx>

**In addition you must also meet all other medical standards for safe driving.** Your doctor should be able to advise you whether you meet the licensing standards. To view the current standards go to [www.gov.uk/dvla/fitnesstodrive](http://www.gov.uk/dvla/fitnesstodrive)

**More information about alcohol and its affect on health can be found at:**  
<https://www.nhs.uk/conditions/Alcohol-misuse/Pages/Introduction.aspx>



### **Applicant's authorisation**

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 share information relevant to the medical assessment of your fitness to drive.
- 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.

For information about how we process your data, your rights and who to contact, see our privacy notice at [www.gov.uk/dvla/privacy-policy](http://www.gov.uk/dvla/privacy-policy)

**This section must NOT be altered in any way.**

#### **Declaration**

I authorise my doctor, specialist or appropriate healthcare professional to disclose medical information or reports about my health condition to the DVLA, on behalf of the Secretary of State for Transport, that is relevant to my fitness to drive.

I understand that the doctor that I authorise, may pass this authorisation to another registered healthcare professional, who will be able to provide information about my medical condition that is relevant to my fitness to drive.

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 and other healthcare professionals such as orthoptists, paramedical staff and the Secretary of State for Transport's Honorary Medical Advisory 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 correspond with medical professionals by email 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



**Note:** please complete and return all pages of this medical questionnaire and authorisation form. 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 completed medical questionnaire to the **Drivers Medical Group**

**By Post:**

Drivers Medical Group,  
DVLA,  
Swansea.  
SA99 1DF

**Email:** [eftd@dvla.gov.uk](mailto:eftd@dvla.gov.uk)

Please keep this page for future reference



Find out about **DVLA's online services**  
Go to: [www.gov.uk/browse/driving](http://www.gov.uk/browse/driving)

