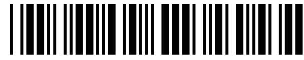
Driver & Vehicle Licensing Agency

Confidential medical information



DG1V
Rev Jul 22

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 ______________

Driver & Vehicle Licensing Agency

Medical questionnaire – substance abuse – vocational

If you are unsure of the answers, we advise you to discuss this form with 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 6 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 ____________________

   ____

   ____

   Date of last contact (Any phone, video or face to face consultation for this condition)

Month	Year

DG1V

4. Within the last 3 years have you used any of the following drugs? Yes ☐ No ☐
(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 ☐

	Yes	Date first used Month/Year		Date last used Month/Year		How much? (quantity used)	How often? (per week / month)
c) Non-prescribed methadone or buprenorphine ?							
d) Cocaine/Crack Cocaine?							
e) Methamphetamine/ Crystal Meth?							
f) Benzodiazepines? (e.g. Diazepam/ Temazepam)							

If yes, are the benzodiazepines 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) ____________________

	Yes	Date first used Month/Year		Date last used Month/Year		How much? (quantity used)	How often? (per week / month)
m) Legal or illegal highs?							

If yes, please give name of drug(s) ____________________

	Yes	Date first used Month/Year		Date last used Month/Year		How much? (quantity used)	How often? (per week / month)
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 ______________________________

   ____

   ____

   Date of last contact (Any phone, video or face to face consultation for this condition) Month ☐ Year ☐

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 ______________________________

   ____

   ____

   Date of last contact (Any phone, video or face to face consultation for this condition) Month ☐ Year ☐

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 of last contact (Any phone, video or face to face consultation for this condition)

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: ____________________

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

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**

Driver & Vehicle
Licensing
Agency

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

Please keep this page for future reference

Find out about **DVLA's online services**
Go to: www.gov.uk/browse/driving