Driver & Vehicle Licensing Agency

Confidential medical information

DG1

DG1
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

DG1
Rev Jan 19

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 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 of last contact		

DG1

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 ☐
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)					
m)	Legal or illegal highs?	☐				
	If yes, please give name of drug(s)					
n)	Solvents?	☐				
	If yes, please give name of drug(s)					

DG1

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 Month ☐☐ Year ☐☐

9. In the last 3 years have you regularly misused or been on dependent 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 Month ☐☐ Year ☐☐

DG1

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

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

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