Confidential medical information

DG1 ONLINE
(Rev Apr 12)

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:

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:

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 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	Reason for attendance	Date last seen

Questionnaire to assess your medical fitness to drive

DG1 ONLINE
(Rev Nov 08)

If you are unsure of the answers, we advise you to discuss this form with your Doctor
Please ensure all questions are answered in full

1. a. Have you used Cannabis in the last three years? YES ☐ NO ☐

   If **YES**, please state quantity, frequency, the date first used and the date last used.

   b. Have you used LSD, Ecstasy or Amphetamine at any time in the last three years? YES ☐ NO ☐

   If **YES**, please give the type, frequency, the date first used and the date last used.

2. Have you used Benzodiazepines for example Diazepam/ Temazepam at any time in the last three years? YES ☐ NO ☐

   If **YES**, please state if prescribed and give the type, quantity, frequency and the date last used.

3. Have you used Cocaine/Crack Cocaine at any time in the last three years? YES ☐ NO ☐

   If **YES**, please give the quantity, frequency and the date last used.

4. Have you used Heroin at any time in the last three years? YES ☐ NO ☐

   If **YES**, please give the quantity, frequency and the date last used.

5. a Have you used Methadone as part of a Drug Rehabilitation Programme at any time in the last three years? YES ☐ NO ☐

   If **YES**, please give the quantity, frequency, the date the programme started and date last used.

NAME	DOB	REF

b. Please give the name and address of your Consultant.

6. Have you used non-prescribed Methadone or any other illicit/street drug not previously mentioned at any time in the last three years? YES ☐ NO ☐

If **YES**, please give the name of the drug(s), quantity, frequency and the date last used.

7. Please list **ALL** prescribed tablets/drugs or medication, including over the counter medication that you are **currently** taking, **including the dosage and please specify the date it was last taken.**

8. Have you suffered with **alcohol problems/alcohol misuse** in the last three years? YES ☐ NO ☐

If **YES**, have you needed treatment for this alcohol problem/alcohol misuse? YES ☐ NO ☐

If **YES**, please give the date and the type of treatment.

	MONTH	**YEAR**

9. Have you suffered from fits/convulsions/seizures/any form of epileptic attack or aura? YES ☐ NO ☐

If **YES**, please give the approximate dates of the following:

	AWAKE	**ASLEEP**
Date of first such attack		
Date of last such attack		

10. Have you suffered with any mental health problems? YES ☐ NO ☐

If **YES**, please give the condition and the name and address of the doctor treating you.

11. Please give the date you were last seen by:

Your Doctor _____ Your Consultant _____

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: _____

CONSENT

Please read the following information carefully and then sign the statement below. This section MUST be completed and must NOT be altered in any way.

Important information about Consent

You will see that we have asked you for your consent for the release of medical reports from your doctors as we may require further information. In addition, as a part of the investigation into your fitness to drive, DVLA may require you to undergo a medical examination or some form of practical assessment.

In these circumstances, those personnel involved will require your background medical details to undertake an appropriate and adequate assessment. Such personnel might include Doctors, Orthoptists at eye clinics or Paramedical Staff at a Driving Assessment centre. Only information relevant to the assessment of your fitness to drive will be released.

In addition, where the circumstances of your case appear exceptional, the relevant medical information would need to be considered by one or more 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.

Consent and 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 authorise the Secretary of State to disclose such relevant medical information as may be necessary to the investigation of my fitness to drive, to Doctors, 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 medical information, discovered during the investigation into my fitness to drive, to Doctor(s)	**YES**	☐	**NO**	☐

Electronic Release of Information

DVLA is able to request and receive medical information by fax and email from you, your doctor(s) or any relevant personnel associated with your medical enquiry

All information held by DVLA is treated with strict confidentiality. E-mails with personal information will be sent by DVLA to medical professionals only where a secure network is available. The security of the electronic transmission of information over the Internet cannot be guaranteed and DVLA cannot accept responsibility for e-mails or faxes sent by others, until they have been received by us. If we are unable to communicate in this way, conventional postage methods will be used instead. You must confirm in writing if you wish to cancel the agreement to communicate electronically.

Do you agree to DVLA communicating with you by fax and / or email	**YES**	☐	**NO**	☐
Do you agree to DVLA communicating with your Doctors, Orthoptists or relevant personnel by fax and / or e-mail?	**YES**	☐	**NO**	☐

NAME	DOB	REF

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

By fax

0845 850 0095

Find out about DVLA's online services

Go to: www.direct.gov.uk/onlinemotoringservices