Driver & Vehicle Licensing Agency

MEDICAL IN CONFIDENCE
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Rev Aug 19

What you need to do:

Step 1	**Step 2**	**Step 3**
Please complete the relevant sections. Sections 3 and 4 must be completed in all instances.	Read the important information relating to invoicing in Section 4	Return the completed questionnaire, along with your invoice, to DVLA using the enclosed return envelope.

Important information

- If you require assistance completing this form, please visit www.gov.uk/dvla/fitnesstodrive
- Before completing the following questions, please read the attached definitions
- If this questionnaire does not bring out relevant clinical details with respect to driving, please give details on a separate sheet. For medico-legal reasons please quote the patient's full name, address and date of birth on the sheet.

Questionnaire to assess your patient's medical fitness to drive

Section 1: Alcohol

1. In the past 6 years has your patient suffered from alcohol dependence? Yes ☐ No ☐

   a) If Yes, are they now free from dependence? Yes ☐ No ☐
   Advice to DVLA states that following a diagnosis of dependence, abstinence is required for 3 years followed by controlled drinking.

   b) If Yes, how long has it been under control? **Years** ☐ **Months** ☐

2. Has there been persistent alcohol misuse in the last 3 years? Yes ☐ No ☐

   a) If Yes, is it now under control? Yes ☐ No ☐
   (Controlled means drinking within Government health guidelines)

   b) If Yes, how long has it been under control? **Years** ☐ **Months** ☐

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3. If known, please provide details of consumption over the last 6 years including amounts and dates?

_____

_____

a) Please give the date last seen **Date** | | | |

4. As a result of alcohol misuse/dependence has your patient required medical detoxification treatment? Yes ☐ No ☐

Please give the date of most recent treatment **Date** | | | |

5. As a result of alcohol dependence, has your patient had any seizure(s) as a direct effect of withdrawing from alcohol? Yes ☐ No ☐

Please give the date of most recent seizure **Date** | | | |

6. To your knowledge has your patient been advised to modify his/her drinking behaviour or abstain from alcohol in the last 6 years? Yes ☐ No ☐

Please give dates if known

_____

_____

_____

7. In the last 6 years has your patient required treatment or help for problems relating to alcohol use? Yes ☐ No ☐

If Yes, was this from:

a) Yourself? ☐ c) Hospital OP/IP? ☐

b) Support group (e.g. AA)? ☐ d) Other? ☐

Please give details _____

_____

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8. Does your patient have any form of non-alcohol related liver disease e.g. infective hepatitis (A/B/C) or other? Yes ☐ No ☐

Please give details _____

_____

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9. In the last 6 years has your patient had blood taken for CDT and/or Gamma GT, AST, ALT and MCV? Yes ☐ No ☐

If Yes, please provide the results with dates or lab reports if available.

_____

_____

a) Are any of these abnormal? Yes ☐ No ☐

Section 2: Drugs

1. In the past 3 years, has your patient demonstrated persistent drug misuse or dependence? Yes ☐ No ☐

Persistent is defined as repeated and/or continually recurring drug use despite the likely risk of harm to the individual or others, and with regard to the standard for physical and mental fitness for driving.

a) If Yes, is it controlled? Yes ☐ No ☐

b) If Yes, how long has it been controlled? **Years** ☐ **Months** ☐

c) Give full details and confirm the type of drug(s)

i) Name of drug(s) _____ _____ _____

ii) Frequency used _____ _____ _____

iii) Date last used ☐☐☐ ☐☐☐ ☐☐☐

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2. In the past 3 years has your patient been on a drug treatment programme e.g. buprenorphine, methadone, naltrexone, for previous opioid drug dependence? Yes ☐ No ☐
If No, please go to question 3.

	Start date Month	Start date Year	End date Month	End date Year
If Yes, please give the date treatment started and ended. (if applicable)				

	Month	Year
Date last seen:		

a) Are you the doctor responsible for overseeing this treatment? Yes ☐ No ☐

If Yes, please read the information below and sign/date the declaration on the next page.
If No, please go to question 3.

Drivers who are being treated for a previous history of opiate misuse can be licensed on a yearly review basis but must meet the following conditions:

- Stable on programme for a minimum of 1 year.
- The treatment programme is supervised by a consultant or specialist GP.
- The treatment is for management of opiate dependency.
- Oral treatment only (not parenteral) but naltrexone implants may be considered.
- There has been compliance with the programme. (Adherence to prescription and appointments, and toxicology testing with sustained stability.)
- No non prescribed psychoactive drug use during the programme or extra use of prescribed drugs such as methadone, buprenorphine, benzodiazepines.
- There is no toxicological evidence of drug misuse.
- There is no adverse effect from treatment likely to affect safe driving.
- There is no alcohol misuse or dependence.
- There are no other relevant medical conditions e.g. mental health issues.
- There should be no other disqualifying conditions. This includes seizures and cardiac problems.

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Declaration

Is your patient able to meet all the criteria? Yes ☐ No ☐

If No, please explain why.

_____

_____

_____

_____

Signature _____ Date _____

3. If your patient has required treatment for drug or other substance misuse in the last 3 years and you are not the provider, please give details and dates including the name and address we should contact for further information.

_____

_____

_____

Name: _____

Address: _____

_____

_____

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Section 3: General

1. Has your patient ever been diagnosed with any of the following problems associated with alcohol misuse or other substance misuse? Yes ☐ No ☐

   If Yes, please indicate which and provide dates and details:

   Details

   a) Memory problems/cognitive impairment? ☐ _____

   b) Mental health problems? ☐ _____

   c) Liver/other GI damage or pancreatitis? ☐ _____

   d) Neurological damage? ☐ _____

   e) Cardiac? ☐ _____

   f) Fits, seizures or blackouts? ☐ _____
   (Please give the date of the most recent event)

2. Please list all medication currently taken by your patient. Please continue on a separate sheet if necessary.

Medication	Dosage	Reason for taking

3. Does your patient suffer any side effects from their medication likely to affect safe driving? Yes ☐ No ☐

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4. Does your patient have any other medical condition likely to affect safe driving? Yes ☐ No ☐

If Yes, please give details

_____

_____

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Section 4: To be completed by a GMC registered doctor

Signature		**Countersignature**	
Name:*		Name:	
Signature:		Signature:	
Job Title:		Job Title:	
Date:		Date:	
GMC No:		GMC No:	
Date of Renewal:		Date of Renewal:	

***If you are NOT medically GMC registered this report must be countersigned by a doctor who is**

Release of the report to your patient

The patient will be entitled to see your report unless you indicate in the box opposite that to release it may cause serious harm to the physical or mental state of patient or a third party. As preserved by Schedule 3 of the Data Protection Act 2018. ☐

Section 5: Payment information

Please ensure a **fully completed** invoice is enclosed.
We will not make a payment without a **complete** invoice.