Medical Examination Report

Notes for applicants for a licence to drive private hire / hackney carriage vehicles

If you are first time applicant for a hackney carriage or private hire licence you will be required to provide evidence of medical fitness. If you have either a PSV or HGV entitlement on your driving licence you do not need to complete this medical report.

The Council has adopted the DVLA Group 2 medical standards which apply to PSV (Public Service Vehicle) or HGV (Heavy Goods Vehicle) licences.

This medical report should normally be completed by the applicant's own general practitioner. However, the applicant may choose to consult an alternative general practitioner for the completion of the report.

If you are applying to renew your existing licence you may need to provide further evidence of medical fitness. Therefore if you are 45, 50, 55, 60, 65 or over 65 then you must arrange for a medical report to be completed by a doctor, or produce evidence of PSV or HGV entitlement on your driving licence.

Before completing this report with your doctor you have advised to read the useful information and notes provided by the DVLA:
http://www.dft.gov.uk/dvla/~/media/pdf/leaflets/INF4D.ashx

If you have any of the conditions listed in this document you will **not** meet the Council's medical standard and your application may be refused. Each application will however be considered on its own merits.

If after reading these notes, you have any doubts about your ability to meet the medical standards, please consult your doctor before you arrange for this medical report to be completed. The doctor may charge you for completing it, and in the event of your application being refused, the fee you pay the doctor is not refundable.

The Licensing Section **must** receive this report, together with your application, within 4 months of the doctor signing the report.

Notes for the doctor completing this medical examination report

Prior to completing this report you may find it helpful to consult the DVLA's "At a glance guide to the current medical standards of fitness to drive" produced for Medical Practitioners:-
http://www.dft.gov.uk/dvla//medical.aspx

You are advised to obtain the applicant's medical history when completing this report, however if you do not hold the medical records, and the report misses important clinical details about the applicant's ability to drive safely, details should be recorded in section 7.

If the applicant is not a patient under your care then please ensure that you confirm their identity before examination. This may be done, for example, by way of photographic identification.

Patient Name		Date of Birth						

1	**Vision** (please see eyesight notes on page x)

	Yes	No
1. Is the visual acuity **at least** 6/9 in the better eye and at least 6/12 in the other? (corrective lenses may be worn) as measured with the full size 6m snellen chart	☐	☐
2. Do corrective lenses have to be worn to achieve this standard? If **YES**, is the:-	☐	☐
(a) Uncorrected acuity at least 3/60 in the right eye?	☐	☐
(b) Uncorrected acuity at least 3/60 in the left eye? (3/60 being the ability to read the 6/60 line of the full size 6m snellen chart at 3 metres)	☐	☐
(c) Correction well tolerated?	☐	☐

3. Please state the visual acuities **of each eye** in terms of the 6m snellen chart. Please convert any 3 metre reading to the 6 metre equivalent.

Uncorrected				Corrected (if applicable)			
Right	☐	Left	☐	Right	☐	Left	☐

	Yes	No
4. Is there a defect in the patient's binocular field or vision (central and/or peripheral)?	☐	☐
5. Is there diplopia? (controlled or uncontrolled)?	☐	☐
6. Does the patient have any other ophthalmic condition?	☐	☐

If **YES** to 4, 5 or 6 please give details in **Section 7** and enclose any relevant visual field charts or hospital letters.

2	**Nervous System**

	Yes	No
Has the patient had any form of epileptic attack? If **YES**, please answer questions (a)-(f)	☐	☐
(a) Has the patient had more than one attack?	☐	☐

(b) Please give date of first and last attack

First Attack D D M M Y Y Last Attack ☐☐☐☐☐☐

	Yes	No
(c) Is the patient currently on anti-epilepsy medication?	☐	☐

(d) If no longer treated, please given date when treatment ended ☐☐☐☐☐☐

	Yes	No
(e) Has the patient had a brain scan? If **YES**, please state:	☐	☐

MRI ☐ Date ☐☐☐☐☐☐ CT ☐ Date ☐☐☐☐☐☐

Patient Name ☐ Date of Birth ☐☐☐☐☐☐

(f) Has the patient had an ECG?

1. Is there a history of blackout or impaired consciousness within the last 5 years? If **YES**, please give date(s) and details in **Section 7**
2. Is there a history of, or evidence of, any of the conditions listed at a-g below?
   If **YES**, please tick the relevant box(es) and give dates and full details at **Section 7**. If **NO**, go to **Section 3**.

   (a) Stroke or TIA *please delete as appropriate*

   If **YES**, please give date

   Has there been a **full** recovery?

   (b) Sudden and disabling dizziness/vertigo within the last 1 year with a liability to recur

   (c) Subarachnoid haemorrhage

   (d) Serious head injury within the last 10 years

   (e) Brain tumour, either benign or malignant, primary or secondary

   (f) Other brain surgery or abnormality

   (g) Chronic neurological disorders e.g. Parkinson's disease, Multiple Sclerosis

3	Diabetes Mellitus

Yes No

Does the patient have diabetes mellitus? If **NO,** please go to **Section 4.** If **YES,** please answer the following questions.

1. Is the diabetes managed by:-

   (a) Insulin?

   If **YES**, please give date started on insulin

   (b) If treated with insulin are there at least 3 months of blood glucose readings stored on a memory meter?

   (c) Other injectable treatments?

   (d) A sulphonylurea or a glinide?

   (e) Oral hypoglycaemic agents and diet?

Patient Name

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(f) Diet only?

2. (a) Does the patient test blood glucose at east twice every day?

   (b) Does the patient test at times relevant to driving?

   (c) Does the patient carry fast acting carbohydrate in the vehicle when driving?

   (d) Does the patient have a clear understanding of diabetes and the necessary precautions for safe driving?

3. Is there evidence of:-

   (a) Loss of visual field?

   (b) Severe peripheral neuropathy, sufficient to impair limb function for safe driving?

4. Is there any evidence of impaired awareness or hypoglycaemia?

5. Has there been laser treatment for retinopathy or intra-vitreal treatment for retinopathy?

   If YES, please give details of treatement

6. Is there a history of hypoglycaemia in the last 12 months requiring the assistance of another person?

If **YES** to any of the 4-6 above, please give details in **Section 7**.

4	**Psychiatric Illness**

Yes No

Is there a history of, or evidence of, any of the conditions listed at 1-7 below?

If **NO**, please go to **Section 5**. If **YES**, please tick the relevant box(es) below and give date(s), prognosis, period of stability and details of medication, dosage and any side effects in **Section 7**.

Yes

1. Significant psychiatric disorder within the past 6 months
2. A psychotic illness within the past 3 years, including psychotic depression
3. Dementia or cognitive impairment
4. Persistent alcohol misuse in the past 12 months
5. Alcohol dependency in the past 3 years

Patient Name

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6. Persistent drug misuse in the past 12 months ☐

7. Drug dependence in the past 3 years ☐

5	**Cardiac**

5A	**Coronary Artery Disease**

	Yes	**No**
Is there a history of, or evidence of Coronary Artery Disease?	☐	☐

If **NO**, go to **Section 5B**. If **YES**, please answer all questions below and give details at **Section 7** of the form.

	Yes	**No**
1. Acute Coronary Syndromes including Myocardial Infarction?	☐	☐
If **YES**, please give date(s) ☐☐☐☐☐☐		
2. Coronary artery by-pass graft surgery?	☐	☐
If **YES**, please give date(s) ☐☐☐☐☐☐		
3. Coronary Angioplasty (P.C.I)	☐	☐
If **YES**, please date of most recent intervention ☐☐☐☐☐☐		
4. Has the patient suffered from Angina?	☐	☐
If **YES**, please date of the last known attack ☐☐☐☐☐☐		

5B	**Cardiac Arrhythmia**

	Yes	**No**
Is there a history of, or evidence of cardiac arrhythmia?	☐	☐

If **NO**, go to **Section 5C.** If **YES**, please answer all questions below and give details at **Section 7** of the form.

	Yes	**No**
1. Has there been a **significant** disturbance of cardiac rhythm? i.e. sinoatrial disease, significant atrio-ventricular conduction defect, atrial flutter / fibrillation, narrow or broad complex tachycardia in last 5 years	☐	☐
2. Has the arrhythmia been controlled satisfactorily for at least 3 months?	☐	☐
3. Has an IDC or biventricular pacemaker (CRST-D type) been implanted?	☐	☐
4. Has a pacemaker been implanted?	☐	☐

If **YES**:-

(a) Please supply date of implementation

(b) Is the patient free of symptoms that caused the device to be fitted?

(c) Does the patient attend a pacemaker clinic regularly?

5C Peripheral Arterial Disease (excluding Buerger's Disease) Aortic Aneurysm / Dissection

Yes **No**

Is there a history of, or evidence of any of the following:
If **YES**, please **tick ALL** relevant boxes below, and give details in **Section 7** of the form. If **NO**, go to **Section 5D**.

1. Peripheral Arterial Disease (excluding Buerger's Disease)

2. Does the patient have claudication?
   If **YES**, for how long in minutes can the patient walk at a brisk pace before being symptom-limited?

   Please give details of treatement

3. Aortic Aneurysm
   If **YES**:

   (a) Site of Aneurysm: Thoracic Abdominal

   (b) Has it been repaired successfully?

   (c) Is the transverse diameter **currently** > 5.5cmc?

If **NO**, please provide latest measurement and date obtained

4. Dissection of the aortic repaired successfully:

5D Valvular / Congenital Heart Disease

Is there a history of, or evidence of valvular / congenital disease?

If **NO**, go to Section 5E. If **YES**, please answer all questions below and give details in **Section 7** f the form

1. Is there a history of congenital heart disorder?

2. Is there a history of heart valve disease?

3. Is there any history of embolism (**not** pulmonary embolism)

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4. Does the patient currently have significant symptoms?

5. Has there been any progression since the last licence application (if relevant)

5E	**Cardiac Other**

Yes **No**

Does the patient have a history of **ANY** of the following conditions:

(a) a history of, or evidence of, heart failure?

(b) established cardiomyopathy?

(c) a heart or heart lung transplant?

(d) untreated atrial myxoma

If **YES**, please give full details in **Section 7** of the form. If **NO**, go to **Section 5F**.

5F	**Cardiac Investigations (this section must be filled in for all patients)**

Yes **No**

1. Has a resting ECG been undertaken?
   If **YES**, does it show:

   (a) pathological Q waves?

   (b) left bundle branch block?

   (c) right bundle branch block?

2. Has an exercise ECG been undertaken (or planned)?

If **YES**, please give date And give details in **Section 7**

3. Has an echocardiogram been undertaken (or planned)?

If **YES**, please give date And give details in **Section 7**

If undertaken, is/was the left ventricular ejection fraction greater than or equal to 40%

4. Has a coronary angiogram been undertaken (or planned)?

If **YES**, please give date And give details in **Section 7**

5. Has a 24 hour ECG tape been undertaken (or planned)

Patient Name

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If **YES**, please give date [ ][ ][ ][ ][ ][ ] And give details in **Section 7**

6. Has a Myocardial Perfusion Scan or Stress Echo study been undertaken (or planned)?

If **YES**, please give date [ ][ ][ ][ ][ ][ ] And give details in **Section 7**

5G	Blood Pressure (this section must be filled in for all patients)

	Yes	No
1. Is today's best systolic pressure reading 180mm Hg or more?		
2. Is today's best diastolic pressure reading 100mm Hg or more?		

Please give today's reading

1. Is the patient on anti-hypertensive treatment?		

If **YES** to any of the above, please provide three previous readings with dates, if available

6	General

Please answer all questions in this section. If your answer is **YES** to any of the questions please give full details in **Section 7**.

	Yes	No
1. Is there **currently** a disability of the spine or limbs likely to impair control of the vehicle?		
2. (a) Is there a history of bronchogenic carcinoma or other malignant tumour, for example, malignant melanoma, with significant liability to metastasise cerebrally?		

If **YES**, please give dates and diagnosis and state whether there is current evidence of dissemination

(b) Is there any evidence the patient has a cancer that causes fatigue or cachexia that affects safe driving?		
3. Is the patient profoundly deaf? If **YES**,		
Is the patient able to communicate in the event of an emergency by speech or by using a device e.g. a textphone		

Patient Name [ ] Date of Birth [ ][ ][ ][ ][ ][ ]

4. Does the patient have a history of alcoholic liver disease and / or liver cirrhosis of any origin? If **YES**, please give details in **Section 7**

5. Is there a history of, or evidence of, sleep apnoea syndrome? If **YES**, please provide details

   (a) Date of diagnosis

   (b) Is it controlled successfully?

   (c) If **YES**, please state treatment

   (d) Please state period of control

   (e) Please provide neck circumference

   (f) Please provide girth measurement in cms

   (g) Date last seen by consultant

6. Does the patient suffer from narcolepsy or cataplexy? If **YES**, please give details in **Section 7**

7. Is there any other **medical condition** causing excessive daytime sleepiness? If **YES**, please provide details

   (a) Diagnosis

   (b) Date of diagnosis

   (c) Is it controlled successfully?

   (d) If **YES**, please state treatment

   (e) Please state period of control

   (f) Date last seen by consultant

8. Does the patient have severe symptomatic respiratory disease causing chronic hypoxia?

9. Does any medication currently taken cause the patient side effects that could affect safe driving? If **YES**, please provide details of medication and symptoms

10. Does the patient have any other medical condition that could affect safe

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driving? If **YES**, please provide details

7	**Notes (if any)**

Patient Name		Date of Birth	

8	**Medical Practitioner Details** (to be completed by the doctor carrying out the examination)

For Medical Practitioners:- At a glance guide to the current medical standards of fitness to drive:- http://www.dft.gov.uk/dvla//medical.aspx

Please ensure all relevant sections of the form have been filled in as, if not, this will cause the form to be returned for completion.

I certify that the applicant named in this medical ✓:-

- **Meets the DVLA group 2** medical standards ☐
- **DOES NOT meet the DVLA group 2** medical standards ☐

I have referred to the applicant's medical records in my completion of this report. **Yes** ☐ **No** ☐

Name

Address

Telephone

Email

Fax

Surgery Stamp or
GMC Registration Number

Signed

Date of Examination

9	**Your Details**

To be filled in in the presence of the Medical Practitioner carrying out the examination.

Please make sure that you have printed your name and date of birth on each page before submitting this form with your application for a licence to drive private hire / hackney carriage vehicles.

Name

Address

Date of Birth

Telephone Number(s)

Email Address

Patient Name

Date of Birth

About your GP / Group Practice

GP / Group Name	
Address	
Phone	
Email Address	
Fax Number	

10	**Patients Declaration**

I authorise my doctor(s) to release information / reports to the Council's Licensing Section about my medical condition.

I declare that I have checked the details I have given in this report 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 and can lead to prosecution.

Signed	

Date								

Patient Name		Date of Birth						