Medical Examination Report

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

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

With effect from 1st October 2015 **all** applications (new and renewal) for a hackney carriage and / or private hire drivers licence **must** be accompanied by a satisfactory medical report to the DVLA Group 2 medical standards. This is regardless of the age of the applicant.

The Council no longer accept evidence of PSV or HGV entitlement on your driving licence as evidence of medical fitness, and a medical report needs to be produced by all applicants.

A further medical report will then be required every 3 years, upon the renewal of an existing licence.

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.

Before completing this report with your doctor you are advised to read the useful information and notes provided by the DVLA (form ref: INF4D):
http://www.dft.gov.uk/dvla/medical/aag.aspx

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 Trading Standards & 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/aag.aspx. **Please be aware that this document was amended by the DVLA in February 2015.**

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 6.

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	

Vision Assessment

To be filled in by a doctor or optician / optometrist

You MUST read the notes in the IND4D leaflet so that you can decide whether you are able to fully complete the vision assessment. The INF4D leaflet is available to download at http://www.dft.gov.uk/dvla/medical/aag.aspx

Please check the applicant's identity before you proceed.

The visual acuity, as measured by the 6 metre Snellen chart, must be at least 6/7.5 (decimal Snellen equivalent 0.8) in the better eye and at least Snellen 6/60 (decimal Snellen equivalent 0.1) in the other eye. Corrective lenses may be worn to achieve this standard. A LogMAR reading is acceptable.

You must answer ALL the following questions

1. Please confirm (✓) the scale you are using to express the driver's visual acuities.

Snellen ☐ Snellen expressed as a decimal ☐ LogMAR ☐

2. Please state the visual acuities of each eye

	Uncorrected		**Corrected (using the prescription worn for driving)**	
Right ☐	Left ☐	Right ☐	Left ☐

3. Please give the best binocular acuity with corrective lenses if worn driving. ☐

	Yes	**No**
4. If **glasses** were worn, was the distance spectacle prescription of either lens used of a corrective power greater than plus 8 (+8) dioptres?	☐	☐
5. If a correction is worn for driving is it well tolerated?	☐	☐

If you answered Yes to ANY of the following, give details in the box provided.

6. Is there a history of any medical condition that may affect the applicant's binocular field of vision (central and/or peripheral)?	☐	☐
7. Is there diplopia?	☐	☐
(a) Is it controlled?	☐	☐

If **Yes,** please ensure you give full details in the box provided.

8. Is there any reason to believe that there is impairment of contrast sensitivity or intolerance to glare?	☐	☐

Patient Name ☐ Date of Birth ☐

9. Does the applicant have any other ophthalmic condition?

Details

Date of examination (see INF4D) D D M M Y Y

Name (print)

Signature

Date of signature D D M M Y Y

Please provide your GOC, HPC or GMC number

Doctor / optometrist / optician's stamp

Patient Name

Date of Birth

Medical Assessment

This assessment must be filled in by a doctor.

- Please check the applicant's identity before you proceed.
- Please ensure you fully examine the applicant as well as taking the applicant's history.
- **Please answer all questions,** and read the notes in the INF4D leaflet (information and useful notes) to help you complete this form – this leaflet is available to download at www.gov.uk/drivingmedicalapplications

1 Nervous System

Please tick ✓ the appropriate box(es)	**Yes**	**No**
1. Has the applicant had any form of seizure? If **NO**, please go to question 2. If **YES**, please answer questions (a) – (f)		
(a) Has the applicant had more than one attack?		
(b) Please give date of first and last attack		

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

(c) Is the applicant currently on anti-epileptic medication?		
(d) If no longer treated, please give date when treatment ended	D D M M Y Y	
(e) Has the applicant had a brain scan? If **YES**, please give details in **section 6**		
(f) Has the patient had an ECG?		
2. Is there a history of blackout or impaired consciousness within the last 5 years? If **YES**, please give date(s) and details in **section 6**		
3. Does the applicant suffer from narcolepsy or cataplexy? If **YES**, please give dates(s) and details in **section 6**		
4. Is there a history of, or evidence of, **ANY** conditions listed at (a) – (h)? If **NO**, go two **question 2**. If **YES**, please give full details at **section 6**.		
(a) Stroke or TIA		
If **YES**, please give date D D M M Y Y		
Has there been a **full** recovery?		
Has a carotid ultra sound been undertaken?		
(b) Sudden and disabling dizziness / vertigo within the last year with a liability to recur		

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(c) Subarachnoid haemorrhage ☐ ☐

(d) Serious traumatic brain injury within the last 10 years ☐ ☐

(e) Any form of brain tumour ☐ ☐

(f) Other brain surgery or abnormality ☐ ☐

(g) Chronic neurological disorders ☐ ☐

(h) Parkinson's disease ☐ ☐

2 Diabetes Mellitus

	Yes	No
1. Does the applicant have diabetes mellitus? If **NO**, please go to **section 3**. If **YES**, please answer the following questions.	☐	☐
2. Is the diabetes managed by:-		
(a) Insulin?	☐	☐
If **YES**, please give date started on insulin D D M M Y Y		
(b) If treated with insulin are there at least 3 months of blood glucose readings stored on a memory meter(s)? If **NO**, please give details in **section 6**	☐	☐
(c) Other injectable treatments?	☐	☐
(d) A Sulphonylurea or a Glinide?	☐	☐
(e) Oral hypoglycaemic agents and diet?	☐	☐
(f) Diet only?	☐	☐
3. (a) Does the applicant test blood glucose at least twice every day?	☐	☐
(b) Does the applicant test at times relevant to driving?	☐	☐
(c) Does the applicant keep fast acting carbohydrate within easy reach when driving?	☐	☐
(d) Does the applicant have a clear understanding of diabetes and the necessary precautions for safe driving?	☐	☐
4. Is there any evidence of impaired awareness of hypoglycaemia?	☐	☐

Patient Name ☐ Date of Birth ☐☐☐☐☐☐

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

6. Is there evidence of:-

   (a) Loss of visual field?

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

If **YES** to any of 4-6 above, please give details in **section 6**

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

If **YES,** please give date(s) of treatment.

3 Psychiatric Illness

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

- If applicant remains under specialist clinic(s), ensure details are filled in at **section 6**

	Yes	No
1. Significant psychiatric disorder within the past 6 months		
2. Psychosis or hypomania / mania within the past 3 years, including psychotic depression		
3. Dementia or cognitive impairment		
4. Persistent alcohol misuse in the past 12 months		
5. Alcohol dependence in the past 3 years		
6. Persistent drug misuse in the past 12 months		
7. Drug dependence in the past 3 years		

If yes to **ANY** of questions 4-7, please state how long this has been controlled

Please give details of past consumption or name of drug(s) and frequency.

4 Cardiac

4A Coronary Artery Disease

	Yes	No
Is there a history of, or evidence of, coronary artery disease? If **NO**, go to **Section 4B**. If **YES**, please answer all questions below and give details at **section 6** of the form.		
1. Has the applicant suffered from Angina?		
If **YES**, please give date of the last known attack (D D M M Y Y)		
2. Acute coronary syndromes including Myocardial infarction?		
If **YES**, please give date (D D M M Y Y)		
3. Coronary angioplasty (P.C.1)?		
If **YES**, please give date of most recent intervention (D D M M Y Y)		
4. Coronary artery by-pass graft surgery?		
If **YES**, please give date (D D M M Y Y)		

4B Cardiac Arrhythmia

	Yes	No
Is there a history of, or evidence of, cardiac arrhythmia? If **NO**, go to **Section 4C**. If **YES**, please answer all questions below and give details in **section 6**		
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 ICD or biventricular pacemaker (CRST-D type) been implanted?		
4. Has a pacemaker been implanted?		

If **YES**:-

(a) Please supply date of implementation (D D M M Y Y)

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

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

4C Peripheral Arterial Disease (excluding Buerger's Disease) Aortic Aneurysm / Dissection

Is there a history or evidence of **ANY** of the following:
If **NO**, go to **section 4D**. If **YES**, please answer all questions below and give details in **section 6**

Yes **No**

1. Peripheral arterial disease (excluding Buerger's Disease)
2. Does the applicant have claudication?
   If **YES**, for how long in minutes can the applicant walk at a brisk pace before being symptom-limited?

   Please give details
3. Aortic Aneurysm
   If **YES**:
   (a) Site of Aneurysm: Thoracic Abdominal
   (b) Has it been repaired successfully?
   (c) Is the transverse diameter **currently** > 5.5 cm?

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

D D M M Y Y

4. Dissection of the aorta repaired successfully
5. Is there a history of Marfan's disease?

4D Valvular / Congenital Heart Disease

Is there a history of, or evidence of, valvular / congenital disease?
If **NO**, go to Section **4E**. If **YES**, please answer all questions below and give details in **section 6** of the form

Yes **No**

1. Is there a history of congenital heart disorder?
2. Is there a history of heart valve disease?

Patient Name

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

4. Does the applicant currently have significant symptoms?

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

4E Cardiac Other

Does the patient have a history of **ANY** of the following conditions:
If **NO**, go to section **4F**. If **YES**, please answer **ALL** questions and give details in **section 6**

	Yes	No
(a) a history of, or evidence of, heart failure?		
(b) established cardiomyopathy?		
(c) has a Left Ventricular Assist Device (LVAD) been implanted?		
(d) a heart or heart / lung transplant?		
(e) untreated atrial myxoma		

4F Cardiac Investigations (this section must be filled in for all applicants)

	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?		

If yes to a, b or c please provide comments at section 6

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

If **YES**, please give date and give details in **section 6** D D M M Y Y

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

(a) If **YES**, please give date and give details in **section 6** D D M M Y Y

(b) If undertaken, is / was the left ejection fraction greater than or equal to 40%.

Patient Name

Date of Birth

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

If **YES**, please give date and give details in **section 6** D D M M Y Y

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

If **YES**, please give date and give details in **section 6** D D M M Y Y

6. Has a myocardial perfusion scan or stress echo study been undertaken (or planned)?

If **YES**, please give date and give details in **section 6** D D M M Y Y

4G Blood Pressure

1. Please record today's blood pressure reading

2. Is the applicant on anti-hypertensive treatment? **Yes** **No**

If **YES** provide three previous readings with dates, if available

D D M M Y Y

D D M M Y Y

D D M M Y Y

5 General

Please answer **ALL** questions. If **YES** to any give full details in **section 6**.

Yes **No**

1. Is there **currently** any functional impairment that is likely to affect control of the vehicle?
2. Is there a history of bronchogenic carcinoma or other malignant tumour with a significant liability to metastasise cerebrally?
3. Is there any illness that may cause significant fatigue or cachexia that affects safe driving?
4. Is the applicant profoundly deaf?

If **YES**, is the applicant 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

5. Does the applicant have a history of liver disease of any origin?
   If **YES**, please give details in **section 6**

6. Is there a history of renal failure? If **YES**, please give details in **section 6**

7. (a) Is there a history of, or evidence of, obstructive sleep apnoea syndrome?

   (b) Is there any other **medical condition** causing excessive daytime sleepiness?

If **YES** please give diagnosis

If **YES**, to 7a or b please give

(i) Date of diagnosis D D M M Y Y

(ii) Is it controlled successfully?

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

(iv) Please state period of control

(v) Date last seen by consultant D D M M Y Y

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

9. Does any medication currently taken cause the applicant side effects that could affect safe driving?
   If **YES**, please provide details of medication and symptoms in **section 6**

10. Does the applicant have an ophthalmic condition?
    If **YES**, please provide details in **section 6**

11. Does the applicant have any other medical condition that could affect safe driving? If **YES**, please provide details in **section 6**

6 Further details

7 Consultants' details

Details of type of specialist(s)/consultants, including address.

Consultant in

Name

Address

Date of last appointment D D M M Y Y

Consultant in

Name

Address

Date of last appointment D D M M Y Y

Patient Name

Date of Birth

Consultant in

Name

Address

Date of last appointment D D M M Y Y

8 Additional Information

Patient's weight (kg)

Height (cms)

Details of smoking habits, if any

Number of alcohol units taken each week

9 Doctors details (please print name and address in capital letters)

To be filled in by doctor carrying out the examination.
Please ensure all sections of the form have been completed. Failure to do so will result in the form being rejected.

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

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

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

Name

Address

Telephone

Email

Fax

Surgery Stamp or
GMC Registration Number

Patient Name

Date of Birth

GMC registration number

Signed

Date of Examination

10 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

About your GP / Group Practice

GP / Group Name

Address

Phone

Email Address

Fax Number

11 Applicants Declaration

I authorise my doctor(s) to release information / reports to the Council's Trading Standards & 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