

Medical Examination Report

Notes for applicants for a private hire / hackney carriage driver licence

All applications 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

A medical will be required every 3 years on application, until the age of 65. <u>From the age of 65</u> a medical will be required annually.

This medical report should **usually** be completed by the applicant's own general practitioner (GP). However, the applicant may choose to consult an alternative GP or Doctor, providing that they can refer to your medical records or a summary of your medical records when carrying out the examination, and sign a declaration confirming this.

Before booking an appointment with a GP or alternative medical provider, you are advised to read the useful information and notes provided by the DVLA at: https://www.gov.uk/government/publications/assessing-fitness-to-drive-a-guide-for-medical-professionals

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.

Please note: Your medical must be no more than 4 months old when your licence is granted.

Notes for the doctor completing this medical examination report

Prior to completing this report you may find it helpful to consult the DVLA's useful information and notes produced for Medical Practitioners at: https://www.gov.uk/government/publications/assessing-fitness-to-drive-a-guide-for-medical-professionals

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 the 'further details' at the back of the form.

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	Date of Birth	
Name	Date of Birth	



Medical examination report for a Group 2 (bus or lorry) licence

For advice on how to fill in this form, read the leaflet INF4D available at **www.gov.uk/reapply-driving-licence-medical-condition**Please use black ink when you fill in this report.

on this report.



Medical professionals must fill in all green sections

Applicants: you must fill in all grey sections of this report. This includes the section below, your full name and date of birth at the end of each page and the declaration on page 8.

declaration on page 8.	Important information for doctors carrying
Important: This report is only valid for	out examinations.
4 months from date of examination.	Before you fill in this report, you must check the applicant's identity and decide if you are able to fill in the Vision
Name	assessment on page 2. If you are unable to do this, you
	must inform the applicant that they will need to ask an
	optician or optometrist to fill in the Vision assessment.
Date of birth	Examining medical professional
Address	Name
	Has a company employed you or booked
	you to carry out this examination? Yes No
	If Yes, you must give the company's details below. If 'No', you must give your practice address details below.
Postcode	(Refer to section C of INF4D.)
Contact number	Company or practice address
Email address	
Date first licensed to drive a bus or lorry	
D D M M Y Y	Postcode
If you do not want to receive survey invitations by email from	Company or practice contact number
DVLA, please tick box	Company of practice contact number
Your doctor's details (only fill in if different from examining doctor's details)	
GP's name	Company or practice email address
	GMC registration number
Practice address	
	I can confirm that I have checked the applicant's
	documents to prove their identity.
	Signature of examining doctor
	Applicant's weight (kg) Applicant's height (cm)
	Applicant's weight (kg) Applicant's height (cm)
Postcode	
Contact number	Number of alcohol units consumed each week
	Units per week
Email address	Does the applicant smoke? Yes No
	Do you have access to the
	applicant's full medical record?

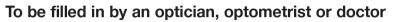


Important: Signatures must be provided at the end of this report



Medical examination report

Vision assessment



D4
LT

1.	Please confirm () the scale you are using to express the applicant's visual acuities. Snellen Snellen expressed as a decimal LogMAR	5. Does the applicant report symptoms of any of the following that impairs their ability to drive? Please indicate below and give full details
2.	The visual acuity standard for Group 2 driving is at least 6/7.5 in one eye and at least 6/60 in the other. (a) Please provide uncorrected visual acuities for each eye. Snellen readings with a plus (+) or minus (-) are not acceptable. If 6/7.5, 6/60 standard is not met, the applicant may need further assessment by an optician.	Please indicate below and give full details in Q7 below. (a) Intolerance to glare (causing incapacity rather than discomfort) and/or (b) Impaired contrast sensitivity and/or (c) Impaired twilight vision
	R L Yes No (b) Are corrective lenses worn for driving? If No, go to Q3.	visual acuity or visual field? If Yes, please give full details in Q7 below.
	If Yes, please provide the visual acuities using the correction worn for driving. Snellen readings with a plus (+) or minus (-) are not acceptable. If 6/7.5, 6/60 standard is not met, the applicant may need further assessment by an optician.	7. Details or additional information
	(c) What kind of corrective lenses are worn to meet this standard? Glasses Contact lenses Both together	
	 (d) If glasses are worn for driving, is the corrective power greater than plus (+)8 dioptres in any meridian of either lens? (e) If correction is worn for driving, is it well tolerated? If No, please give full details in Q7. 	Name of examining doctor, optician or optometrist undertaking vision assessment I confirm that this report was filled in by me at examination and the applicant's history has been
3.	Is there a history of any medical condition that may affect the applicant's binocular field of vision (central and/or peripheral)? If Yes, please give full details below.	taken into consideration. Signature of examining doctor, optician or optometrist
	If formal visual field testing is considered necessary, DVLA will commission this at a later date.	Date of signature Please provide your GOC or GMC number
4.	Is there diplopia? (a) Is it controlled? Please indicate below and give full details in Q7. Patch or Glasses Other glasses with frosted glass prism provide details)	Doctor, optometrist or optician's stamp
Apı	plicant's full name Please do not o	Date of birth DDMMYY detach this page



Medical examination report

Medical assessment

Must be filled in by a doctor

1 Neurological disorders	2 Diabetes mellitus
Please tick ✓ the appropriate boxes Is there a history or evidence of any neurological disorder (see conditions in questions 1 to 11 below)? If No, go to section 2, Diabetes mellitus If Yes, please answer all questions below and enclose relevant hospital notes.	Yes No Does the applicant have diabetes mellitus? If No, go to section 3, Cardiac If Yes, please answer all questions below. 1. Is the diabetes managed by: (a) Insulin? Yes No Yes No
Yes No 1. Has the applicant had any form of seizure? (a) Has the applicant had more than one seizure episode? (b) If Yes, please give date of first and last episode. First episode Last episode Last episode (c) Is the applicant currently on anti-epileptic medication? If Yes, please fill in the medication section 8, page 6. (d) If no longer treated, when did treatment end? (e) Has the applicant had a brain scan? If Yes, please give details in section 9, page 7. (f) Has the applicant had an EEG? If you have answered Yes to any of above, you must supply medical reports.	If No, go to 1c If Yes, please give date started on insulin. (b) Are there at least 6 continuous weeks of blood glucose readings stored on a memory meter or meters? If No, please give details in section 9, page 7. (c) Other injectable treatments? (d) A Sulphonylurea or a Glinide? (e) Oral hypoglycaemic agents and diet? If Yes to any of (a) to (e), please fill in the medication section 8, page 6. (f) Diet only? 2. (a) Does the applicant test blood glucose at least twice every day? (b) Does the applicant test at times relevant to driving (no more than 2 hours before the start of the first journey and every
dissociative/'non-epileptic' seizures? (a) If Yes, please give date of most recent episode. (b) If Yes, have any of these episode(s) occurred or are they considered likely to occur whilst driving?	2 hours while 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?
3. Stroke or TIA? If Yes, give date. (a) Has there been a full recovery? (b) Has a carotid ultrasound been undertaken? (c) If Yes, was the carotid artery stenosis >50% in either carotid artery? (d) Is there a history of multiple strokes/TIAs?	 3. (a) Has the applicant ever had a hypoglyaemic episode? (b) If Yes, is there full awareness of hypoglycaemia? 4. Is there a history of hypoglycaemia in the last 12 months requiring the assistance of another person? If Yes, please give details and dates below.
4. Sudden and disabling dizziness or vertigo within the last year with a liability to recur?	
5. Subarachnoid haemorrhage (non-traumatic)?	5 Is there evidence of: Yes No
6. Significant head injury within the last 10 years?	(a) Loss of visual field? (b) Severe peripheral neuropathy, sufficient
7. Any form of brain tumour?	to impair limb function for safe driving?
8. Other intracranial pathology?	V - N
9. Chronic neurological disorder(s)?	6. Has there been laser treatment or intra-vitreal treatment for retinopathy?
10. Parkinson's disease?11. Blackout, impaired consciousness or loss of awareness within the last 10 years?	If Yes, please give most recent date of treatment.
Applicant's full name	Date of birth DDMMYY

3 Cardiac		c Peripheral arterial disease (excluding Buerger's disease)
a Coronary artery disease		aortic aneurysm/dissection
Is there a history or evidence of coronary artery disease? If No, go to section 3b, Cardiac arrhythmia If Yes, please answer all questions below and enclose relevant hospital notes.	Yes No	Is there a history or evidence of peripheral arterial disease (excluding Buerger's disease), aortic aneurysm or dissection? If No, go to section 3d, Valvular/congenital heart disease If Yes, please answer all questions below and enclose relevant hospital notes.
Has the applicant ever had an episode of angina? If Yes, please give the date	Yes No	1. Peripheral arterial disease? Yes No (excluding Buerger's disease)
of the last known attack. 2. Acute coronary syndrome including myocardial infarction? If Yes, please give date.	Yes No	Yes Note 2. Does the applicant have claudication? If Yes, would the applicant be able to undertake 9 minutes of the standard Bruce Protocol ETT?
3. Coronary angioplasty (PCI)? If Yes, please give date of most recent intervention.	Yes No	3. Aortic aneurysm? If Yes: (a) Site of aneurysm: Yes No
4. Coronary artery bypass graft surgery? If Yes, please give date.	Yes No	(a) Site of anedrysm. Abdominal (b) Has it been repaired successfully? (c) Please provide latest transverse aortic diameter measurement and date obtained
5. If Yes to any of the above, are there any physical health problems or disabilities (e.g. mobility, arthritis or COPD) that would make the applicant unable to undertake 9 minutes of standard Bruce Protocol ETT? Please give deta	the	using measurement and date obtained using measurement and date boxes.
Standard Bruce Frotocor ETT: Trease give deta	ans below.	4. Dissection of the aorta repaired successfully? Yes No lf Yes, please provide copies of all reports including those dealing with any surgical treatment.
b Cardiac arrhythmia		5. Is there a history of Marfan's disease? Yes No lif Yes, please provide relevant hospital notes.
Is there a history or evidence of cardiac arrhythmia?	Yes No	d Valvular/congenital heart disease
If No, go to section 3c, Peripheral arterial diseal If Yes, please answer all questions below and encrelevant hospital notes.		Is there a history or evidence of valvular or congenital heart disease? If No, go to section 3e, Cardiac other
 Has there been a significant disturbance of cardiac rhythm? (e.g. sinoatrial disease, significant atrio-ventricular conduction defect, atrial flutter or fibrillation, narrow or broad 	Yes No	If Yes, answer all questions below and provide relevant hospital notes. Yes No.
complex tachycardia) in the last 5 years?	Van Na	1. Is there a history of congenital heart disease?
2. Has the arrhythmia been controlled satisfactorily for at least 3 months? 2. Has an IOD (to a least 3 continue Definition).	Yes No	2. Is there a history of heart valve disease? Yes No
3. Has an ICD (Implanted Cardiac Defibrillator) or biventricular pacemaker with defibrillator/ cardiac resynchronisation therapy defibrillator (CRT-D type) been implanted?	Yes No	3. Is there a history of aortic stenosis? If Yes, please provide relevant reports (including echocardiogram).
4. Has a pacemaker or a biventricular pacemaker/ cardiac resynchronisation therapy pacemaker (CRT-P type) been implanted? If Yes:	Yes No	4. Is there history of embolic stroke?
(a) Please give date of implantation. (b) Is the applicant free of the symptoms that		5. Does the applicant currently have significant symptoms?
caused the device to be fitted? (c) Does the applicant attend a pacemaker clinic regularly?		6. Has there been any progression (either clinically or on scans etc) since the last licence application?
Applicant's full name		Date of birth

e Cardiac other				e: If Yes to questions 2 to 6, please give dates in the boxe ided, give details in section 9, page 7 and provide releval	
Is there a history or evidence of heart failure? If No, go to section 3f, Cardiac channelopathies	Yes	No	2.	Has an exercise ECG been undertaken (or planned)?	es No
If Yes, please answer all questions and enclose relevant hospital notes. 1. Please provide the NYHA class,		_	3.	Has an echocardiogram been undertaken (or planned)?	es No
if known.	Vac	No		(a) If undertaken, is or was the left ejection	
2. Established cardiomyopathy? If Yes, please give details in section 9, page 7.	Yes	NO	4	fraction greater than or equal to 40%? Has a coronary angiogram been undertaken Ye	s No
3. Has a left ventricular assist device (LVAD) or other cardiac assist device been implanted?	Yes	No		(or planned)?	
4. A heart or heart/lung transplant?	Yes Yes		5.	Has a 24 hour ECG tape been undertaken (or planned)?	s No
5. Untreated atrial myxoma?	Tes		6.	Has a loop recorder been implanted (or planned)?	es No
f Cardiac channelopathies			7	Lies a muse sevelial menticaism seem, etvess	- Na
Is there a history or evidence of the following conditions? If No, go to section 3g, Blood pressure		No	7.	Has a myocardial perfusion scan, stress echo study or cardiac MRI been undertaken (or planned)?	es No
1. Brugada syndrome?	Yes	No	4	Psychiatric illness	
2. Long QT syndrome? If Yes to either, please give details in section 9, page 7 and enclose relevant hospital notes.	Yes	No	illn	there a history or evidence of psychiatric ess within the last 3 years? No, go to section 5, Substance misuse (es, please answer all questions below.	es No
g Blood pressure				10 T	es No
All questions must be answered. If resting blood pressure is 180 mm/Hg systolic or and/or 100mm/Hg diastolic or more, please take a 2 readings at least 5 minutes apart and record the of the 3 readings in the box provided. 1. Please record today's best resting blood pressure reading.	i furthe best			Psychosis or hypomania/mania within the past 12 months, including psychotic depression? (a) Dementia or cognitive impairment? (b) Are there concerns which have resulted in ongoing investigations for such possible diagnoses?	es No
2. Is the applicant on anti-hypertensive treatment? If Yes, please provide three previous readings with dates if available.	Yes	No	5		
	YY	7	or If N	there a history of drug/alcohol misuse Yedependence? No, go to section 6, Sleep disorders Yes, please answer all questions below.	es No
7 D D M M	V ₁ z	Nie	1.	Is there a history of alcohol dependence in the past 6 years?	es No
3. Is there a history of malignant hypertension? If Yes, please give details in section 9, page 7 (including date of diagnosis and any treatment etc)	Yes			(a) Is it controlled?(b) Has the applicant undergone an alcohol detoxification programme?If Yes, give date started:	
h Cardiac investigations				Ye	es No
Have any cardiac investigations been undertaken or planned?	Yes	No	2.	Persistent alcohol misuse in the past 3 years? (a) Is it controlled?	
If No, go to section 4, Psychiatric illness If Yes, please answer questions 1 to 7.			3.	Use of illegal drugs or other substances, or misuse Ye of prescription medication in the last 6 years?	es No
1. Is there a history of the following:(a) left bundle branch block (LBBB)?(b) right bundle branch block (RBBB)?If yes to (a) or (b), please provide relevant	Yes	No		(a) If Yes, the type of substance misused?(b) Is it controlled?(c) Has the applicant undertaken an opiate	
report(s) or comment in section 9, page 7.				treatment programme? If Yes, give date started	YY
Applicant's full name				Date of birth D D M M	YY

6	Sleep disorders	6. Does the applicant have a history of liver disease of any origin?
1.	Is there a history or evidence of Obstructive Yes N Sleep Apnoea Syndrome or any other medical condition causing excessive sleepiness? If No, go to section 7, Other medical conditions.	
	If Yes, please give diagnosis and answer all questions below.	7. Is there a history of renal failure? If Yes, please give details in section 9, page 7.
	a) If Obstructive Sleep Apnoea Syndrome, please indicate the severity:	8. Does the applicant have severe symptomatic Yes No respiratory disease causing chronic hypoxia?
	Mild (AHI <15) Moderate (AHI 15 - 29) Severe (AHI >29) Not known If another measurement other than AHI is used, it	9. Does any medication currently taken cause the applicant side effects that could affect safe driving? If Yes, please fill in section 8, Medication and give symptoms in section 9, page 7.
	must be one that is recognised in clinical practice as equivalent to AHI. DVLA does not prescribe different measurements as this is a clinical issue. Please give details in section 9 page 7, Further details	condition that could affect safe driving?
	 b) Please answer questions (i) to (vi) for all sleep conditions. (i) Date of diagnosis: 	No Please provide details of all current medication including eye drops (continue on a separate sheet if necessary).
	(iii) If Yes, please state treatment.	Medication Dosage
	(iv) Is applicant compliant with treatment? Yes N (v) Please state period of control:	No Reason for taking: Approximate date started (if known):
	years months (vi) Date of last review.	Medication Dosage Reason for taking:
7	Other medical conditions	Approximate date started (if known):
1.	Is there a history or evidence of narcolepsy?	No Medication Dosage
2.	Is there currently any functional impairment Yes N that is likely to affect control of the vehicle?	No Reason for taking: Approximate date started (if known):
3.	Is there a history of bronchogenic carcinoma Yes or other malignant tumour with a significant liability to metastasise cerebrally?	No Medication Dosage
4.	Is there any illness that may cause significant Yes Natigue or cachexia that affects safe driving?	No Reason for taking: Approximate date started (if known):
5.	If Yes, is the applicant able to communicate	No Medication Dosage
	in the event of an emergency by speech or by using a device, e.g. a textphone?	No Reason for taking: Approximate date started (if known):
App	olicant's full name	Date of birth DDMMYY

9 Further details	10 Consultants' details
Please send us copies of relevant hospital notes. Do not send any notes not related to fitness to drive. Use the	Please provide details of type of specialists or consultants, including address.
space below to provide any additional information.	Consultant in
	Reason for attendance
	Name
	Address
	Date of last appointment:
	Consultant in
	Reason for attendance
	Name
	Address
	Date of last appointment:
	If more consultants seen give details on a separate sheet.
	11 Examining doctor's signature and stamp
	To be filled in by the doctor carrying out the examination.
	Please make sure all sections of the form have been filled in. The form will be returned to you if you do not do this.
	I confirm that this report was filled in by me at examination and I have taken the applicant's history into account. I also confirm that I am currently GMC registered and licensed to practise in the UK or I am a doctor who is medically registered within the EU, if the report was filled in outside the UK.
	Signature of examining doctor
	Date of signature
	Doctor's stamp
Applicant's full name	Date of birth DDMMYY

The applicant must fill in this page Applicant's declaration

You must fill in this section and must not alter it in any way.

Please read the following important information carefully then 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

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

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	
Louishavian the Conveters of State to	
I authorise the Secretary of State to correspond with medical professionals electronic channels (fax and/or email)	s via
Yes No	
Checklist	
 Have you signed and dated the declaration? 	Yes
 Have you checked that the optician, optometrist or doctor has filled in all parts of the report and all relevant hospital notes have been enclosed? 	Yes
Important This report is valid for 4 months from	
the date the doctor, optician or	

optometrist signs it.

Please return it together with your application form.

To be filled in by doctor carrying out the examination.

For Medical Practitioners:- An at a glance guide to the current medical standards of fitness to drive is available at:- https://www.gov.uk/government/publications/assessing-fitness-to-drive-a-guide-for-medical-professionals

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 **Please ensure you, the GP / approved medical provider, confirm if you have referred to the medical records or a summary of the medical records of the applicant, when carrying out the examination. Failure to do so will result in the form being rejected.** I have referred to the applicant's medical records in my completion of this report. OR I have referred to a summary of the applicant's medical records in my completion of this report. GMC registration number Signed Date of Examination Surgery Stamp or **GMC Registration Number Applicants 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