# 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. From 65 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: <a href="https://www.gov.uk/government/publications/assessing-fitness-to-drive-a-guide-for-medical-professionals">https://www.gov.uk/government/publications/assessing-fitness-to-drive-a-guide-for-medical-professionals</a>

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: <a href="https://www.gov.uk/government/publications/assessing-fitness-to-drive-a-guide-for-medical-professionals">https://www.gov.uk/government/publications/assessing-fitness-to-drive-a-guide-for-medical-professionals</a>

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 Name	Date of Birth	
alient	Rirth	



# 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.



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.

Important: This report is only valid for 4 months from date of examination.												
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Medical professionals must fill in all green sections on this report.

#### Important information for doctors carrying out examinations.

Before you fill in this report, you must check the applicant's identity and decide if you are able to fill in the Vision

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



### **Medical examination report**

### Vision assessment



1	
	14

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?  Yes No
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  6. Does the applicant have any other ophthalmic condition affecting their
	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
	Co 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 (if other please provide details)	Doctor, optometrist or optician's stamp
Ар	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

**D4** 

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  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
2. Has the applicant experienced yes No 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?	<ul> <li>3. (a) Has the applicant ever had a hypoglyaemic episode?</li> <li>(b) If Yes, is there full awareness of hypoglycaemia?</li> <li>4. Is there a history of hypoglycaemia in the last 12 months requiring the assistance of another person?</li> </ul>
(d) Is there a history of multiple strokes/TIAs?  4. Sudden and disabling dizziness or vertigo within the last year with a liability to recur?	If Yes, please give details and dates below.
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?
<ul><li>10. Parkinson's disease?</li><li>11. Blackout, impaired consciousness or loss of awareness within the last 10 years?</li></ul>	If Yes, please give most recent date of treatment.
Applicant's full name	Date of birth

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 diseas 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 of the last known attack.	Yes No	1. Peripheral arterial disease? Yes N (excluding Buerger's disease)
2. Acute coronary syndrome including myocardial infarction?  If Yes, please give date.	Yes No	Yes N  2. Does the applicant have claudication?  If Yes, would the applicant be able to undertake 9
3. Coronary angioplasty (PCI)?  If Yes, please give date of most recent intervention.	Yes No	minutes of the standard Bruce Protocol ETT?  Yes  Aortic aneurysm?  If Yes:
<ul><li>4. Coronary artery bypass graft surgery?</li><li>If Yes, please give date.</li><li>5. If Yes to any of the above, are there any</li></ul>	Yes No	<ul> <li>(a) Site of aneurysm: Thoracic Abdominal</li> <li>(b) Has it been repaired successfully?</li> <li>(c) Please provide latest transverse aortic diameter measurement and date obtained using measurement and date boxes.</li> </ul>
physical health problems or disabilities (e.g. mobility, arthritis or COPD) that would make the applicant unable to undertake 9 minutes of t standard Bruce Protocol ETT? Please give detai	:he	4. Dissection of the aorta repaired successfully? Yes If 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?  If Yes, please provide relevant hospital notes.
Is there a history or evidence of cardiac arrhythmia?  If No, go to section 3c, Peripheral arterial diseas If Yes, please answer all questions below and encrelevant hospital notes.		d Valvular/congenital heart disease  Is there a history or evidence of valvular or congenital heart disease?  If No, go to section 3e, Cardiac other
1. 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  1. Is there a history of congenital heart disease?
<ul><li>complex tachycardia) in the last 5 years?</li><li>2. Has the arrhythmia been controlled satisfactorily for at least 3 months?</li></ul>	Yes No	Yes N  2. Is there a history of heart valve disease?
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?  Yes  Yes  Yes  Yes  Yes
(a) Please give date of implantation.  (b) Is the applicant free of the symptoms that		significant symptoms?
caused the device to be fitted?  (c) Does the applicant attend a pacemaker clinic regularly?		clinically or on scans etc) since the last licence application?
Applicant's full page		Pate of high

e Cardiac other			vided, give details in section 9, page 7 and provide releva		port
Is there a history or evidence of heart failure?  If No, go to section 3f, Cardiac channelopathies	Yes 1	No 2.	Has an exercise ECG been undertaken (or planned)?	Yes I	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)?	Yes I	No
if known.  2. Established cardiomyopathy?	Yes 1	No	(a) If undertaken, is or was the left ejection fraction greater than or equal to 40%?		
<ul><li>If Yes, please give details in section 9, page 7.</li><li>3. Has a left ventricular assist device (LVAD) or other cardiac assist device been implanted?</li></ul>	Yes I	No 4.	Has a coronary angiogram been undertaken Y (or planned)?	es l	No
4. A heart or heart/lung transplant?	Yes 1		Has a 24 hour ECG tape been undertaken (or planned)?	es [	No
5. Untreated atrial myxoma?	Yes I		Has a loop recorder been implanted (or planned)?	Yes	No
f Cardiac channelopathies					
Is there a history or evidence of the following conditions?  If No, go to section 3g, Blood pressure			Has a myocardial perfusion scan, stress echo study or cardiac MRI been undertaken (or planned)?	Yes	No
1. Brugada syndrome?	Yes	No	Psychiatric illness		
2. Long QT syndrome?  If Yes to either, please give details in section 9, page 7 and enclose relevant hospital notes.	Yes	ill	there a history or evidence of psychiatric ness within the last 3 years?  No, go to section 5, Substance misuse Yes, please answer all questions below.	Yes	No
g Blood pressure			10 T	Yes	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.	further	r 2.	past 12 months, including psychotic depression?		No No
Is the applicant on anti-hypertensive treatment?     If Yes, please provide three previous readings with dates if available.	Yes I	No	in ongoing investigations for such possible diagnoses?		
/ DDMM / DDMM	YY	Is or		Yes	No
			Is there a history of alcohol dependence in the past 6 years?	res [	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 I	No	(a) Is it controlled? (b) Has the applicant undergone an alcohol detoxification programme?		
h Cardiac investigations			If Yes, give date started:	Yes	No
Have any cardiac investigations been undertaken or planned?  If No, go to section 4, Psychiatric illness	Yes I	No 2.	Persistent alcohol misuse in the past 3 years?  (a) Is it controlled?		
If Yes, please answer questions 1 to 7.	Voc. I		Use of illegal drugs or other substances, or misuse of prescription medication in the last 6 years?  (a) If Yes, the type of substance misused?	Yes	No
<ul><li>1. Is there a history of the following:</li><li>(a) left bundle branch block (LBBB)?</li><li>(b) right bundle branch block (RBBB)?</li><li>If yes to (a) or (b), please provide relevant report(s) or comment in section 9, page 7.</li></ul>	Yes I	No	(b) Is it controlled? (c) Has the applicant undertaken an opiate treatment programme?  If Yes, give date started	Y	
Applicant's full name			Date of birth	V	V

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 Y Sleep Apnoea Syndrome or any other medical condition causing excessive sleepiness?  If No, go to section 7, Other medical condition	es No	If Yes, is this the result of alcohol misuse?  If Yes, please give details in section 9, page 7.
	If Yes, please give diagnosis and answer all que 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, plea indicate the severity:	se	8. Does the applicant have severe symptomatic Yes respiratory disease causing chronic hypoxia?
	Mild (AHI <15)  Moderate (AHI 15 - 29)  Severe (AHI >29)  Not known  If another measurement other than AHI is us	ed, 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 pra as equivalent to AHI. DVLA does not prescril different measurements as this is a clinical is Please give details in section 9 page 7, Further	oe sue.	<ul><li>10. Does the applicant have any other medical Yes No condition that could affect safe driving?</li><li>If Yes, please provide details in section 9, page 7.</li></ul>
	b) Please answer questions (i) to (vi) for <b>all</b> slee conditions.	р	8 Medication
	(i) Date of diagnosis:  (ii) Is it controlled successfully?  (iii) If Yes, please state treatment.	es No	Please provide details of all current medication including eye drops (continue on a separate sheet if necessary).
	(iii) ii les, piease state treatment.		Medication Dosage
	(iv) Is applicant compliant with treatment?	es No	Reason for taking:
	(v) Please state period of control:		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?	es No	Medication Dosage
2.	Is there currently any functional impairment Ye that is likely to affect control of the vehicle?	es No	Reason for taking:  Approximate date started (if known):
3.	Is there a history of bronchogenic carcinoma or other malignant tumour with a significant liability to metastasise cerebrally?	es No	Medication Dosage
4.	Is there any illness that may cause significant $\frac{Y_0}{f}$ fatigue or cachexia that affects safe driving?	es No	Reason for taking:  Approximate date started (if known): DDMMYY
5.	is the applicant profoundly dear?	es No	Medication Dosage
	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?	es No	Reason for taking:
	or by doing a device, e.g. a textpriorie:		Approximate date started (if known):
App	olicant's full name		Date of birth

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 to drive.

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	
I authorise the Secretary of State to correspond with medical professionals electronic channels (fax and/or email)	via
Yes No	
Checklist	<b>7</b>
<ul> <li>Have you signed and dated the declaration?</li> </ul>	es
<ul> <li>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?</li> </ul>	es
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.

Name

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

I certify that th	ne applicant named in this medical ✓:-
<ul><li>Meets</li></ul>	the DVLA group 2 medical standards
• DOES	NOT meet the DVLA group 2 medical standards
to the medica	ure you, the GP / approved medical provider, confirm if you have referred al records or a summary of the medical records of the applicant, when the examination. Failure to do so will result in the form being rejected.**
I have referre this report.	ed to the applicant's medical records in my completion of
OR	
	ed to a summary of the applicant's medical records in on of this report.
GMC registra	ation number
Signed	Date of Examination
Surgery Stan GMC Registr	np or ration Number
Applicants	Declaration
•	doctor(s) to release information / reports to the Council's Licensing Section dical condition.
I declare that l knowledge an	I have checked the details I have given in this report and that, to the best of my d belief, they are correct. I understand that it is a criminal offence if I make a on and can lead to prosecution.
Signed	
Date	
Patient	Date of

Birth