PRESTON CITY COUNCIL
LICENSING SERVICES
ENVIRONMENTAL HEALTH DEPARTMENT
TOWN HALL
LANCASTER ROAD
PRESTON
PR1 2RL

MEDICAL EXAMINATION REPORT GROUP 2 LICENCE ENTITLEMENT FOR HACKNEY CARRIAGE AND PRIVATE HIRE DRIVERS

VERSION DATE 16th August 2013

MEDICAL EXAMINATION REPORT
VISION ASSESSMENT

To be filled in by a Doctor or optician/optometrist

- **Doctors –** You **MUST** read the notes in the **INF4D leaflet** so that you can decide whether you are able to fully complete the vision assessment. Please visit https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1025896/inf4d-d4-medical-examination-information-notes.pdf

- Please check the applicant's identity before you proceed and also request **proof** of the applicant's application for a private hire or hackney carriage driver's licence **with Preston City Council.**

- 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.

- **If correction is needed to meet the eyesight standard for driving, ALL questions must be answered. If correction is NOT needed, questions 4 and 5 can be ignored.**

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 acuity of each eye.
Please convert any 3 metre readings to the 6 metre equivalent.

Uncorrected		Corrected (using the prescription worn for driving)	
R	L	R	L

3. Please give the best binocular acuity (with corrective lenses if worn for driving).

Please tick ✓ the appropriate boxes	**YES**	**NO**
4. If glasses are worn, was the distance spectacle prescription of either lens used of a corrective power greater than 8 (+8) dioptres	☐	☐
5. If a correction is worn for driving, is it well tolerated	☐	☐

If you answer Yes to ANY of the following, give details in the box provided overleaf

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	☐ ☐	☐ ☐

Applicant's name **DOB**

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

9. Does the applicant have any other ophthalmic condition? ☐ ☐

Details

Date of examination (see INF4D) DD MM YY

Name (print)

Signature

Date of signature DD MM YY

Please provide your GOC, HPC or GMC number

Doctor/optometrist/optician's stamp

Applicant's name **DOB**

MEDICAL EXAMINATION REPORT MEDICAL ASSESSMENT
Must be filled in by a doctor

- Please check the **applicant's identity** before you proceed and also request proof of the applicant's application for a private hire or hackney carriage driver's licence **with Preston City Council.**
- Please check that this medical examination report is the most **recent version** by visiting the following web address and checking the version date.
  Link to driver
- 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** (visit https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1025896/inf4d-d4-medical-examination-information-notes.pdf Information and useful notes) and the **DVLA At A Glance Guide** (visit https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1084397/assessing-fitness-to-drive-may-2022.pdf) to help you complete this form.

1 Nervous System

Please tick ✓ the appropriate boxes	**YES**	**NO**
1. Has the applicant had any form of seizure? If NO, 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 DD MM YY Last Attack DD MM YY

c) Is the applicant currently on anti-epileptic medication? If **YES,** please fill in current medication in **section 8**	☐	☐

d) If no longer treated, please give date when treatment ended DD MM YY

e) Has the applicant had a brain scan? If **YES** please give details in **section 6**	☐	☐
f) Has the applicant had an EEG?	☐	☐

If **YES** to any of the above, please supply reports if available

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 details of date(s) and details in **section 6**

4. Is there a history of, or evidence of **ANY** of the conditions listed at a-h below?	☐	☐

Applicant's name _____ **DOB** _____

If **NO,** go to **Section 2.**

If **YES,** please give full details at **Section 6** and supply any relevant reports.

a) Stroke or TIA ☐

If **YES,** please give date DD MM YY has there been a **full** recovery? ☐ ☐

Has a carotid ultra sound been undertaken? ☐

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

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

Please tick ✓ the appropriate boxes	**YES**	**NO**
1. Does the applicant have diabetes mellitus? If **NO,** please proceed 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 DD MM YY	☐	☐
b) If treated with insulin are there at least 3 months of blood glucose readings stored on a memory meter(s)?	☐	☐
c) Other injectable treatments?	☐	☐
d) A sulphonylurea or a Glinide?	☐	☐
e) Oral hypoglycaemic agents and diets? If **YES**, to any of a-e fill in current medication in **section 8**	☐	☐
f) Diet only?	☐	☐
3.a) Does the applicant test blood glucose at least twice every day?	☐	☐
b) Does the patient test at times relevant to driving?	☐	☐
c) Does the applicant 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?	☐	☐
4. Is there any evidence of impaired awareness of hypoglycaemia?	☐	☐

Applicant's name _____ **DOB** _____

5. Is there a history of hypoglycaemia during 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

DD	MM	YY

3 Psychiatric Illness

Please tick ✓ the appropriate boxes **YES** **NO**

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

- Please enclose relevant hospital notes
- If applicant remains under specialist clinic(s), ensure details are filled in at section 7.

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 dependency 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

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 and enclose relevant hospital notes.

Please tick ✓ the appropriate boxes **YES** **NO**

1. Has the applicant suffered from Angina? ☐ ☐

Applicant's name **DOB**

If **YES**, please give the date of last known attack DD MM YY

2. Acute coronary syndromes including Myocardial infarction? ☐ ☐

If **YES**, please give date(s) DD MM YY

3. Coronary Angioplasty (P.C.I) ☐ ☐

If **YES**, please give date of most recent intervention DD MM YY

4. Coronary artery by-pass graft surgery? ☐ ☐

If **YES**, please give the date DD MM YY

4B Cardiac Arrhythmia

Please tick ✓ the appropriate boxes	**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 at **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 implantation DD MM YY		
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

Please tick ✓ the appropriate boxes	**YES**	**NO**
Is there a history of, 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**	☐	☐
1. Peripheral arterial disease (excluding Buerger's Disease**)**	☐	☐
2. Does the applicant have claudication? If **YES** for how long in minutes can the patient walk at a brisk pace before being symptom-limited? Please give details;	☐	☐

3. Aortic aneurysm ☐ ☐

Applicant's name **DOB**

IF **YES:**

a) Site of Aneurysm: Thoracic ☐ Abdominal ☐

b) Has it been repaired successfully? ☐ ☐

c) Is the transverse diameter **currently** > 5.5cm? ☐ ☐

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

	DD	MM	YY

4. Dissection of the aorta repaired successfully ☐ ☐
If **YES,** please provide copies of all reports to include those dealing with any surgical treatment

5. Is there a history of Marfan's disease? ☐ ☐
If **YES,** provide relevant hospital notes

4D Valvular/Congenital Heart Disease

Please tick ✓ the appropriate boxes	**YES**	**NO**
Is there a history of, or evidence of, valvular/congenital heart disease?	☐	☐

If **NO,** go to **Section 4E**

If **YES,** please answer all questions below and give details at **Section 6** of 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)	☐	☐
4. Does the applicant currently have significant symptoms?	☐	☐
5. Has there been any progression since the last licence application? (if relevant)	☐	☐

4E Cardiac other

Please tick ✓ the appropriate boxes	**YES**	**NO**
Does the applicant 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**

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

Applicant's name **DOB**

Please tick ✓ the appropriate boxes **YES** **NO**

This section must be completed for all applicants.

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 a copy of the ECG report or comment at **Section 6***

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

If **YES**, please give date and give details in **Section 6** DD MM YY
Please provide relevant reports if available

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

a) If **YES** please give date and give details in **Section 6** DD MM YY

b) If undertaken, is/was the left ejection fraction greater than or equal to 40%? ☐ ☐
Please provide relevant reports if available

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

If **YES**, please give date and give details in **Section 6** DD MM YY
Please provide relevant reports if available

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

If **YES**, please give date and give details in **Section 6** DD MM YY
Please provide relevant reports if available

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** DD MM YY
Please provide relevant reports if available

4G Blood Pressure

Please tick ✓ the appropriate boxes **YES** **NO**

1. Please record today's blood pressure reading

2. Is the applicant on anti-hypertensive treatment? ☐ ☐

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

	DD	MM	YY
	DD	MM	YY
	DD	MM	YY

5 General

Applicant's name **DOB**

Please tick ✓ the appropriate boxes **YES** **NO**

Please answer **ALL** questions. IF **'YES'** to any give full details in **Section 6.**

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 text phone? ☐ ☐

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 diagnosis

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

(i) Date of Diagnosis DD MM YY

(ii) Is it controlled successfully? ☐ ☐

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

(iv) Please state period of control

(v) Date last seen by consultant DD MM YY

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

9. Does the 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 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

Please forward copies of relevant hospital notes.

Applicant's name **DOB**

PLEASE DO NOT send any notes not related to fitness to drive.

7 Consultants' details

Details of type of specialists(s)/consultants, including address

Consultant in
Name
Address

Date of last appointment

DD	MM	YY

Consultant in

Applicant's name **DOB**

Name
Address

Date of last appointment | DD | MM | YY |

Consultant in
Name
Address

Date of last appointment | DD | MM | YY |

8 Medication

Please provide details of all current medication (continue on a separate sheet if necessary)

Medication	Dosage
Reason for taking:	

Medication	Dosage
Reason for taking:	

Medication	Dosage
Reason for taking:	

Medication	Dosage
Reason for taking:	

Medication	Dosage
Reason for taking:	

9 Additional information

Applicant's name **DOB**

Patients' weight (kg)	
Height (cms)	
Details of smoking habits, if any	
Number of alcohol units taken each week	

Examining Doctor's details

- **To be completed by the 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.**

10 Doctor's details (please print name and address in capital letters)

Name
Address
Telephone
Email address
Fax number

Surgery Stamp and GMC Registration Number

1) I confirm that I have access or have requested access to the applicant's medical records in assessing the applicant's fitness to undertake the duties of a Hackney Carriage/Private hire driver and

2) I confirm that having due regard to the current publication of the DVLA 'At a Glance Guide' and Group 2 entitlement, that the applicant named below is*(please tick as appropriate):-

***FIT**		**to undertake the duties of a Hackney Carriage or Private Hire Driver**
***UNFIT**		

Name of applicant:

_____

Signature of Medical Practitioner	
Date of examination	

Applicant's Details

Applicant's name | **DOB**

- **To be completed 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 sending this form with your application.**

11 Your details

Your full name		Date of Birth	DD	MM YY
Your address		Home tel. no.		
		Work/Day no.		
Email address				

About your GP/Group Practice

GP/Group name		
Address		
	Telephone	
	Email address	
	Fax number	

12 Applicant's consent and declaration

Consent and Declaration
This section **MUST** be completed and must **NOT** be altered in any way. Please read the following important information carefully then sign the statements below.

Important information about Consent
On occasion, as part of the investigation into your fitness to drive, Preston City Council may require further information from your doctor and orthoptist at an eye clinic. Only information relevant to the assessment of your fitness to drive will be released. In addition, the relevant information might need to be considered by the Council's Taxi and Miscellaneous Sub-Committee.

Consent and Declaration

- **I authorise my Doctor(s) and Specialist(s) to release report/medical information about my condition, relevant to my fitness to drive a hackney carriage or private hire vehicle, to Preston City Council.**
- **I authorise Preston City Council to disclose such relevant medical information as may be necessary to the investigation of my fitness to drive, to doctors, paramedical staff, Medical Advisory Panels and on occasion to the Council's Taxi and Miscellaneous Sub-Committee.**
- **I understand that it is a criminal offence if I make a false declaration to obtain a hackney carriage or private hire vehicle driver's licence with Preston City Council and can lead to prosecution.**
- **I authorise Preston City Council to inform my doctor(s) of the outcome of my case and release reports to my Doctor(s)**
- **I declare that I have checked the details I have given on the Medical Examination Report attached and that, to the best of my knowledge and belief, they are correct.**

Name:	**Signature:**
Date	

Applicant's name | **DOB**