



# MEDICAL EXAMINATION REPORT FOR A GROUP 2 (DUAL HACKNEY CARRIAGE AND PRIVATE HIRE DRIVER LICENCE)

This medical report is for the confidential use of the Licensing Authority and will be used in determining an applicant's suitability to hold a Hackney Carriage or Private Hire Vehicle Driver's Licence.

## NOTE TO APPLICANT

Your application must be supported by a valid Medical Report completed by your own Doctor or General Practitioner (GP) or by a medical practitioner who has reviewed your full medical history.

Medical reports are required for every licence application up to the age of 65 years. All licensed drivers aged 65 years and over must submit an annual medical examination report to the Council.

Medical reports must be less than 3 months old when submitted to the Council.

**All parts of this form must be completed in the presence of your doctor.**

## To be completed by Applicant

Applicant's name

Address including postcode

Telephone Number

Email

Date of Birth

## NOTE TO DOCTOR

The Council has adopted the Driver and Vehicle Licensing Agency (DVLA) Group II medical standard, which applies to heavy goods vehicles (HGV) and public service vehicles (PSV), as the medical standard for Hackney Carriage/Private Hire Vehicle Driver Licences.

Further information is available at <https://www.gov.uk/government/publications/assessing-fitness-to-drive-a-guide-for-medical-professionals>

All sections of this report must be completed in full.

### To be completed by Doctor carrying out the examination

Practitioner Name

Surgery Stamp

Surgery Address

Surgery Telephone Number

Surgery Email

# Medical examination report

## Medical assessment

Must be filled in by a doctor

- Please check the applicant's identity before you proceed.
- Please ensure you fully examine the applicant and take the applicant's history.

### 1 Neurological disorders

Please tick ✓ the appropriate box(es)

Is there a history of, or evidence of any neurological disorder? Yes No

If No, go to section 2

If Yes, please answer all the questions below, give details in section 6 and enclose relevant hospital notes.

- Yes No
1. Has the applicant had any form of seizure?
- (a) Has the applicant had more than one attack?
- (b) Please give date of first and last attack
- First attack
- Last attack
- (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
- (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 above, please supply reports if available.

- Yes No
2. Stroke or TIA?
- If Yes, please give date
- Has there been a FULL recovery?
- Has a carotid ultrasound been undertaken?
- If Yes, was the carotid artery stenosis >50% in either carotid artery?
3. Sudden and disabling dizziness/vertigo within the last year with a liability to recur?
4. Subarachnoid haemorrhage?
5. Serious traumatic brain injury within the last 10 years?
6. Any form of brain tumour?
7. Other brain surgery or abnormality?
8. Chronic neurological disorders?
9. Parkinson's disease?
10. Is there a history of blackout or impaired consciousness within the last 5 years?
11. Does the applicant suffer from narcolepsy?

### 2 Diabetes mellitus

Does the applicant have diabetes mellitus? Yes No

If No, go to section 3

If Yes, please answer all the questions below.

- Yes No
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 continuous 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?
- If Yes to any of (a)-(e), please fill in current medication in section 8.
- (f) Diet only?
- Yes No
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 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?
- Yes No
3. Is there any evidence of impaired awareness of hypoglycaemia?
- Yes No
4. Is there a history of hypoglycaemia in the last 12 months requiring the assistance of another person?
- If Yes, please give dates and details in section 6
- Yes No
5. 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 4-5 above, please give details in section 6
- Yes No
6. Has there been laser treatment or intra-vitreous treatment for retinopathy?
- If Yes, please give date(s) of treatment.
- 

Applicant's full name

Date of birth

### 3 Cardiac

#### a Coronary artery disease

Is there a history of, or evidence of, coronary artery disease?  Yes  No

If **No**, go to **section 3b**

If **Yes**, please answer **all** questions below and give details at **section 6** of the form and enclose relevant hospital notes.

1. Has the applicant suffered from angina?  Yes  No

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

2. Acute coronary syndrome including myocardial infarction?  Yes  No

If **Yes**, please give date  DD  MM  YY

3. Coronary angioplasty (PCI)?  Yes  No

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

4. Coronary artery bypass graft surgery?  Yes  No

If **Yes**, please give date  DD  MM  YY

5. If **Yes** to any of the above, are there any physical health problems (e.g. mobility/arthritis, COPD) that would make the applicant unable to undertake 9 minutes of the standard Bruce Protocol ETT?  Yes  No

#### b Cardiac arrhythmia

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

If **No**, go to **section 3c**

If **Yes**, please answer **all** questions below and give details in **section 6**, and enclose relevant hospital notes.

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 the last 5 years?  Yes  No

2. Has the arrhythmia been controlled satisfactorily for at least 3 months?  Yes  No

3. Has an ICD or biventricular pacemaker (CRT-D type) been implanted?  Yes  No

4. Has a pacemaker been implanted?  Yes  No

If **Yes**:

(a) Please give date of implantation  DD  MM  YY

(b) Is the applicant free of the symptoms that caused the device to be fitted?  Yes  No

(c) Does the applicant attend a pacemaker clinic regularly?  Yes  No

#### c Peripheral arterial disease (excluding Buerger's disease) aortic aneurysm/dissection

Is there a history of, or evidence of, peripheral arterial disease (excluding Buerger's disease), aortic aneurysm/dissection?  Yes  No

If **No**, go to **section 3d**

If **Yes**, please answer **all** questions below and give details in **section 6** and enclose relevant hospital notes.

1. Peripheral arterial disease (excluding Buerger's disease)  Yes  No

2. Does the applicant have claudication?  Yes  No  
If **Yes**, how long in minutes can the applicant walk at a brisk pace before being symptom-limited?   
Please give details

3. Aortic aneurysm?  Yes  No

If **Yes**:

(a) Site of aneurysm: Thoracic  Abdominal

(b) Has it been repaired successfully?  Yes  No

(c) Is the transverse diameter **currently** > 5.5 cm?  Yes  No

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

DD  MM  YY

4. Dissection of the aorta repaired successfully?  Yes  No  
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?  Yes  No  
If **Yes**, please provide relevant hospital notes

#### d Valvular/congenital heart disease

Is there a history of, or evidence of, valvular/congenital heart disease?  Yes  No

If **No**, go to **section 3e**

If **Yes**, please answer **all** questions below and give details in **section 6** and enclose relevant hospital notes.

1. Is there a history of congenital heart disease?  Yes  No

2. Is there a history of heart valve disease?  Yes  No

3. Is there a history of aortic stenosis?  Yes  No  
If **Yes**, please provide relevant reports

4. Is there any history of embolism? (not pulmonary embolism)  Yes  No

5. Does the applicant currently have significant symptoms?  Yes  No

6. Has there been any progression since the last licence application? (if relevant)  Yes  No

Applicant's full name

Date of birth

DD  MM  YY

**e Cardiac other**

Is there a history of, or evidence of heart failure?  Yes  No

If No, go to section 3f

If Yes, please answer all questions and enclose relevant hospital notes.  Yes  No

1. Established cardiomyopathy?  Yes  No

2. Has a left ventricular assist device (LVAD) been implanted?  Yes  No

3. A heart or heart/lung transplant?  Yes  No

4. Untreated atrial myxoma?  Yes  No

**f Cardiac channelopathies**

Is there a history of, or evidence of either of the following conditions?  Yes  No

If No, go to section 3g  Yes  No

1. Brugada syndrome?  Yes  No

2. Long QT syndrome?  Yes  No

If Yes to either, please give details in section 6 and enclose relevant hospital notes.

**g Blood pressure**

If resting blood pressure is 180 mm/Hg systolic or more and/or 100mm Hg diastolic or more, please take a further 2 readings at least 5 minutes apart and record the best of the 3 readings in the box provided.

1. Please record today's best resting blood pressure reading

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

If Yes, please provide three previous readings with dates if available

DD MM YY  
  DD MM YY  
  DD MM YY

3. Is there a history of malignant hypertension?  Yes  No

If Yes, please provide details in section 6 (including date of diagnosis and any treatment etc)

**h Cardiac investigations**

Have any cardiac investigations been undertaken or planned?  Yes  No

If No, go to section 4

If Yes, please answer questions 1-6  Yes  No

1. Has a resting ECG been undertaken?  Yes  No

If Yes, does it show:

(a) pathological Q waves?  Yes  No

(b) left bundle branch block?  Yes  No

(c) right bundle branch block?  Yes  No

If Yes to a, b or c please provide a copy of the relevant ECG report or comment at section 6.

Applicant's full name

Date of birth  DD MM YY

2. Has an exercise ECG been undertaken (or planned)?  Yes  No

If Yes, please give date  DD MM YY

and give details in section 6

Please provide relevant reports if available

3. Has an echocardiogram been undertaken (or planned)?  Yes  No

(a) If Yes, please give date  DD MM YY

and give details in section 6

(b) If undertaken, is/was the left ejection fraction greater than or equal to 40%?  Yes  No

Please provide relevant reports if available

4. Has a coronary angiogram been undertaken (or planned)?  Yes  No

If Yes, please give date  DD MM YY

and give details in section 6

Please provide relevant reports if available

5. Has a 24 hour ECG tape been undertaken (or planned)?  Yes  No

If Yes, please give date  DD MM YY

and give details in section 6

Please provide relevant reports if available

6. Has a myocardial perfusion scan or stress echo study been undertaken (or planned)?  Yes  No

If Yes, please give date  DD MM YY

and give details in section 6

Please provide relevant reports if available

**4 Psychiatric illness**

Is there a history of, or evidence of, psychiatric illness, drug/alcohol misuse within the last 3 years?  Yes  No

If No, go to section 5

If Yes, please answer all questions below

1. Significant psychiatric disorder within the past 6 months?  Yes  No

2. Psychosis or hypomania/mania within the past 12 months, including psychotic depression?  Yes  No

3. Dementia or cognitive impairment?  Yes  No

4. Persistent alcohol misuse in the past 12 months?  Yes  No

5. Alcohol dependence in the past 3 years?  Yes  No

6. Persistent drug misuse in the past 12 months?  Yes  No

7. Drug dependence in the past 3 years?  Yes  No

If 'Yes' to any questions above, please provide full details in section 6 including dates, period of stability and where appropriate consumption and frequency of use.

## 5 General

All questions must be answered. If Yes to any, give full details in section 6 and enclose relevant hospital notes.

1. Is there a history of, or evidence of, Obstructive Sleep Apnoea Syndrome or any other medical condition causing excessive sleepiness? **Yes** **No**

If Yes, please give diagnosis

- a) If Obstructive Sleep Apnoea Syndrome, please indicate the severity

Mild (AHI <15)

Moderate (AHI 15 - 29)

Severe (AHI >29)

Not known

If another measurement other than AHI is used, it 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 6.

- b) Please answer questions (i) – (vi) for all sleep conditions

(i) Date of diagnosis           **Yes** **No**

(ii) Is it controlled successfully?

(iii) If Yes, please state treatment

**Yes** **No**

(iv) Is applicant compliant with treatment?

(v) Please state period of control

(vi) Date of last review

2. Is there **currently** any functional impairment that is likely to affect control of the vehicle? **Yes** **No**

3. Is there a history of bronchogenic carcinoma or other malignant tumour with a significant liability to metastasise cerebrally? **Yes** **No**

4. Is there any illness that may cause significant fatigue or cachexia that affects safe driving? **Yes** **No**

5. Is the applicant profoundly deaf? **Yes** **No**  
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?

6. Does the applicant have a history of liver disease of any origin? **Yes** **No**  
   
If Yes, please give details in section 6

7. Is there a history of renal failure? **Yes** **No**  
If Yes, please give details in section 6

8. Does the applicant have severe symptomatic respiratory disease causing chronic hypoxia? **Yes** **No**

9. Does any medication currently taken cause the applicant side effects that could affect safe driving? **Yes** **No**  
   
If Yes, please provide details of medication and symptoms in section 6

10. Does the applicant have any other medical condition that could affect safe driving? **Yes** **No**  
   
If Yes, please provide details in section 6

## 6 Further details

Please forward copies of relevant hospital notes. Please do not send any notes not related to fitness to drive.

Applicant's full name

Date of birth

## 7 Consultants' details

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

Consultant in
Name
Address

Date of last appointment

Consultant in
Name
Address

Date of last appointment

Consultant in
Name
Address

Date of last appointment

## 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:	

Applicant's full name

Date of birth

     

## 9 Additional information

Patient's weight (kg)

Height (cms)

Details of smoking habits, if any

Number of alcohol units taken each week

## 10 Examining doctor's signature and stamp

To be completed by the doctor carrying out the examination. Please ensure all sections of the form have been completed. The form will be returned to you if you don't do this.

I confirm that this report was completed by me at examination. I also confirm that I am currently GMC registered and licensed to practice in the UK or I am a doctor who is medically registered within the EU, if the report was completed outside of the UK.

Signature of practitioner

Date of signature

     

Doctor's stamp

## To be completed by the Practitioner

I certify that I have reviewed the full medical history of the applicant and have examined him/her. The answers given in response to this medical are correct to the best of my knowledge and belief.

I confirm that:-

<input type="checkbox"/>	The applicant meets the Medical Standard to drive as laid down by the DVLA
<input type="checkbox"/>	The applicant does not meet the Medical Standard to drive as laid down by the DVLA

Name of Practitioner

Signature of Practitioner

Date Signed

## To be completed by the Applicant

### Declaration

I authorise my doctor and specialist to release reports and information about my condition which is relevant to my fitness to drive, to Newcastle-under-Lyme Borough Council. I understand that Newcastle-under-Lyme Borough Council may disclose relevant medical information that is necessary to investigate my fitness to drive.

I declare that I have checked the details on this report and that they are correct to the best of my knowledge. I understand that it is a criminal offence if I make a false declaration to obtain a license and can lead to prosecution.

Signature of Applicant

Name of Applicant

Dated Signed

As part of the investigation into your fitness to drive, Newcastle-under-Lyme Borough Council may require you to have a further medical examination, a medical investigation or some form of practical assessment in addition to this medical report. If we do, the people involved will need your medical details to carry out an appropriate assessment and only relevant information will be provided.

### General Data Protection Regulations 2018

Newcastle under Lyme Borough Council is registered as a Data Controller under the General Data Protection Regulation 2018. Further details can be found at <https://www.newcastle-staffs.gov.uk/all-services/advice/data-protection>

Where necessary for the Council's Regulatory, Public Health and Community Safety functions, e.g. Building Control, Environmental Health, Licensing, Planning, Anti-Social Behaviour, Crime Prevention and Reduction, Safeguarding; information obtained about you and persons connected with you may be held and processed by the Council. This may also be shared with others under information sharing protocols or where required or allowed by law. Such information will only be held by the Council for as long as necessary and in line with our published Retention Policy.