SHEFFIELD CITY COUNCIL – TAXI DRIVERS MEDICALS

Register of Doctors/Medical Practices available to Applicants

Name and Address	Booking Details	Cost	Available Times	Further Comments
Stonecroft Medical Centre 871 Gleadless Road Sheffield S12 2LJ	www.hgv-medical.co.uk	£60	Mon – Wed Friday lunchtime	
Birley Health Centre 120 Birley Lane Sheffield S12 3BP	Diane Levick 0845 1221881 Michael Boyle GP	£100	Monday am Monday 6pm - 7:30pm Thursday 6pm – 7:30pm	Results issued within 1 week
Barnsley Road Surgery 899 Barnsley Road Sheffield S5 QJ	0844 5769269	£80		
Mathews Practice, 22 Asline Road Sheffield S2 4UJ	Dr G Chetty 07968 977 272 Email: gasan2206@googlemail.com	£40		
Sloan Medical Practice Little London Road Sheffield S8 0TW	0845 127 2001	£80	Flexible times to suit drives – can offer daytime	
Sheffield City GP Health Centre Rockingham House 75 Broad Lane Sheffield S1 3PD	0114 241 2700 www.walkinwhenyouneedsus.com	£80	8am to 8pm 7 days a week	Registered patients - £65. Credit & Debit cards accepted.
Sharrow Lane Medical Centre 129 Sharrow lane Sheffield S11 8AN	Dr Madhu 0114 2493458	£30	Flexible times arranged with the Doctor	
Pitsmoor Surgery 151 Burngreave Road Sheffield S3 9DL	Dr Claire Richardson 0114 272 5154	£100	Once a month on a Wednesday morning	Costs for specialist reports if needed.
Porter Brook Medical Centre 9 Sunderland Street Sheffield S11 8HN	0114 263 6100	£92	Saturday morning only	Registered patients only

Duke Medical Centre 28 Talbot Road Sheffield S2 2TD	Contact Lynsey Hardy Tel 2720689 / 2262803	£80 + VAT	Monday to Friday	
Walkley House Medical Centre 23 Greenhow Street Sheffield S6 3TN	0114 234 3561	£50	Appointments at various times during the week	
Handsworth Medical Practice 432 Handsworth Road Sheffield S13 9BZ	Tel Nicola or Claire 0114 2697505 / 2293171	£50- £60	Monday to Friday	
Veritas Health Centre 243-245 Chesterfield Road Sheffield S8 0RT	Practice Manager 0845 1242627	£100	Flexible Times Arranged with the Doctor	
Carrfield Medical Centre Carrfield Street Sheffield S8 9SG	Dr Singh Mobile 07976810786	£30	Flexible times to suit (Weekdays)	
Brinsworth Medical Centre 171 Bawtry Road Rotherham S60 5ND	Dr Singh Mobile 07976810786	£30	Flexible times to suit (Weekdays)	
Burgreave Surgery 5 Burgreave Road Sheffield S3 9DA	Dr Mooney Contact is 0114 2725619	£45	Monday to Friday Flexible times arrange with the Doctor	
The Medical Centre 1a Ingfield Avenue Tinsley Sheffeld S9 1WZ	Dr N M Okorie 01142 610623	£70	Mon, Tue, Wed Between 1pm & 3pm	
Just Health Clinic Greasbro Road Tinsley Sheffield S9 1UQ	https://just-health.co.uk/taximedical/ Call 01282 936900	£60	Nationwide clinics 45 + Locations Open 7 days a week Open in Sheffield Saturdays	Lead Doctor Dr Sohail Ansar Just Health Operations Manager Naureen Akhta

Dr O'Connell The Sheffield Clinic Ltd CFC House Woodseats Close S8 0TB	0345 5081448 07976243146			Available for ECG and Treadmill Tests only

Please forward the completed medical forms in paper form either via the post or alternatively it can be posted through the letter box at the Licensing Reception at the Staniforth Road Depot.

Please provide as a PDF document if emailing

Sheffield City Council

Taxi Licensing

MEDICAL EXAMINATION REPORT

Please answer ALL questions

Please give patient's weight (kg/st) _____ height (cms/ft) _____

Please give details of smoking habits, if any _____

Please give number of alcohol units taken each week _____

Is the urine analysis positive for Glucose? No ☐ Yes ☐ (please tick appropriate box)

Details of specialist(s)/ consultants, including address	1	2	3
Speciality			
Date last seen			

Medication	Dosage	Reason Taken

Date when first licensed to drive a lorry _____ and/or bus _____

1 Vision

Please tick ✓ the appropriate box(es) **YES** **NO**

Applicant Name:……

Applicant Date of Birth:……

1. Is the visual acuity at least 6/9 in the better eye and at least 6/12 in the other? (corrective lenses may be worn) as measured with the full size 6m Snellen chart ☐ ☐

2. Do corrective lenses have to be worn to achieve this standard? If **YES**, is the:- ☐ ☐

   (a) uncorrected acuity at least 3/60 in the right eye? ☐ ☐

   (b) Uncorrected acuity at least 3/60 in the left eye? (3/60 being the ability to read the 6/60 line of the full size 6m Snellen chart at 3 metres) ☐ ☐

   (c) Correction well tolerated? ☐ ☐

Please tick ✓ the appropriate box(es) **YES** **NO**

3. Please state the visual acuities **of each eye** in terms of the 6m Snellen chart Please convert any 3 metre readings to the 6 metre equivalent.

Uncorrected			**Corrected (if applicable)**		
Right		Left	Right		Left

4. **Is there a defect in his/her binocular field of vision** (central and/or peripheral)? ☐ ☐

5. Is there diplopia? (controlled or uncontrolled) ☐ ☐

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

   If **YES** to 4,5, or 6, please give details in **Section 7** and enclose any relevant visual field charts or hospital letters.

2 Nervous System

YES **NO**

1. Has the applicant had any form of epileptic attack? ☐ ☐

   (a) If **YES**, please give date of last attack ☐☐ ☐☐ ☐☐

   (b) If treated, please give date when treatment ceased ☐☐ ☐☐ ☐☐ ☐ ☐

   (c) Is the applicant currently on anti-epileptic medication?

   If **YES**, please complete current medication on the appropriate section on the front of this form

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 7**

Applicant Name:……

Applicant Date of Birth:……

NO

3. Does the applicant suffer from narcolepsy/cataplexy? ☐ ☐

If **YES**, please give date(s) and details in **Section 7**

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

If **NO**, go to Section 3

If **YES**, please tick the relevant box(es) and give dates and full details at **Section 7**.

(a) Stroke/TIA *please delete as appropriate* ☐

If **YES**, please give date ☐☐ ☐☐ ☐☐

Has there been a full recovery ☐ ☐

YES

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

(c) Subarachnoid haemorrhage ☐

(d) Serious head injury within the last 10 years ☐

(e) Brain tumour, either benign or malignant, primary or secondary ☐

(f) Other brain surgery ☐

(g) Chronic neurological disorders e.g. Parkinson's disease, Multiple Sclerosis ☐

(h) Dementia or cognitive impairment ☐

3 Diabetes Mellitus

YES **NO**

1. **Does the applicant have diabetes mellitus?** ☐ ☐

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

If **YES**, please answer the following questions.

2. Is the diabetes managed by:-

Applicant Name:……

Applicant Date of Birth:……

(a) Insulin? ☐ ☐

If **YES**, please give date started on insulin ☐☐ ☐☐ ☐☐

(b) Exenatide/Byeta ☐ ☐

(c) Oral hypoglycaemic agents and diet? ☐ ☐

If **YES**, please complete current medication on the appropriate section on the front of this form

(d) Diet only? ☐ ☐

3. Does the applicant test blood glucose at least twice every day? ☐ ☐

4. Is there evidence of:- ☐ ☐

(a) Loss of visual field? ☐ ☐

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

(c) Diminished/Absent awareness of hypoglycaemia? ☐ ☐

5. Has there been laser treatment for retinopathy? If **YES**, please give date(s) of treatment ☐

Applicant Name:……

Applicant Date of Birth:……

	YES	NO
6. Is there a history of hypoglycaemia during **waking** hours in the last 12 months requiring assistance from a third party?	☐	☐

If **YES** to any of 4-6 above, please give details in **Section 7.**

4 Psychiatric Illness

	YES	NO
Is there a history of, or evidence of any of the conditions listed at 1-6 below?	☐	☐

If **NO**, please go to **Section 5**

If **YES**, please tick the relevant box(es) below and give date(s), prognosis, period of stability and details of medication, dosage and any side effects in **Section 7.**

NB. Please enclose relevant hospital notes

NB. If applicant remains under specialist clinic(s) ensure details are completed at the top of page 1.

	YES
1. Significant psychiatric disorder within the past 6 months	☐
2. A psychotic illness within the past 3 years, including psychotic depression	☐
3. Persistent alcohol misuse in the past 12 months	☐
4. Alcohol dependency in the past 3 years	☐
5. Persistent drug misuse in the past 12 months	☐
6. Drug dependency in the past 3 years	☐

5 Cardiac

Please follow the instructions in all Sections (5A-5G) giving details as required in Section 7 and enclose hospital notes relevant to this condition.

NB. If applicant remains under specialist cardiac clinic(s) ensure details are completed on page 1.

5A

Applicant Name:……

Applicant Date of Birth:……

Coronary Artery Disease

	YES	NO
Is there a history of, or evidence of, coronary artery disease?	☐	☐

If **NO,** proceed to **Section 5B**

YES

If YES please answer all questions below and give details at Section 7 of the form.

1. Acute Coronary Syndrome including Myocardial Infarction? ☐ ☐
   If **Yes**, please give date(s) ☐☐ ☐☐ ☐☐
2. Coronary artery by-pass graft surgery? ☐ ☐
   If **Yes**, please give date(s) ☐☐ ☐☐ ☐☐
3. Coronary Angioplasty (P.C.I) ☐ ☐
   If **Yes,** please give date(s) ☐☐ ☐☐ ☐☐
4. Has the applicant suffered from Angina? ☐ ☐
   If **Yes**, please give the date of the last attack ☐☐ ☐☐ ☐☐

Please proceed to next section 5B

5B Cardiac Arrhythmia

	YES	NO
Is there a history of, or evidence of, cardiac arrhythmia?	☐	☐

If **NO**, proceed to **Section 5C**

If **YES** please answer all questions below and give details at **Section 7** of the form

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 a cardiac defibrillator device (I.C.D) been implanted?	☐	☐
4. Has a pacemaker been implanted?	☐	☐

Applicant Name:……

Applicant Date of Birth:……

NO

If **YES:-**

(a) Please supply date ☐☐ ☐☐ ☐☐

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

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

Please proceed to next section 5C

5C Peripheral Arterial Disease (excluding Buerger's Disease)

	YES	NO
1. Is there a history or evidence of ANY of the below:	☐	☐
If **YES** please **tick** ✓ ALL relevant boxes below, and give details at **Section 7** of the form.	☐	☐
PERIPHERAL ARTERIAL DISEASE (excluding Buerger's Disease)	☐	☐
2. Does the patient have claudication?		
If **YES** how long in minutes can the patient walk at a brisk pace before being symptom limited Please give details ☐		
AORTIC ANEURYSM	☐	☐
IF **YES:**		
(a) Site of Aneurysm: **Thoracic** ☐ **Abdominal** ☐		
(b) Has it been repaired successfully?	☐	☐
(c) Is the transverse diameter **currently** 5.5cms?	☐	☐
DISSECTION OF THE AORTA	☐	☐
IF REPAIRED SUCCESSFULLY:	☐	☐
Please provide sight of reports to confirm if available		

Please proceed to next Section 5D

5D

Applicant Name:……

Applicant Date of Birth:……

Valvular/Congenital Heart Disease

	YES	NO
Is there a history of, or evidence, of valvular/congenital heart disease?	☐	☐

If **NO**, proceed to **Section 5E**

If **YES** please answer all questions below and give details at **Section 7** 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 license application? (if relevant)	☐	☐
Please proceed to next section 5E	☐	☐

Applicant Name:……

Applicant Date of Birth:……

5E C Cardiac Other

	YES	NO
Does the applicant have a history of ANY of the following conditions:	☐	☐
(a) a history of, or evidence of heart failure?		
(b) Established cardiomyopathy?		
(c) A heart or heart/lung transplant?		

If YES to any part of the above, please give full details in Section 7 of the form. If NO, proceed to next section 5F

5F Cardiac Investigations

This section must be completed 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?	☐	☐
2. Has an exercise ECG been undertaken (or planned?)	☐	☐
If **YES**, please give date and give details in **Section 7** ☐☐ ☐☐ ☐☐		
Please provide if available		
3. Has an echocardiogram been undertaken (or planned)?	☐	☐
a) If **YES**, please give date ☐☐☐☐ ☐☐ ☐☐ and ☐☐ give details in **Section 7**		
b) If undertaken, is/was the left ventricular ejection fraction greater than or equal to 40%?	☐	☐
Please provide if available		
4. Has a coronary angiogram been undertaken (or planned)?	☐	☐

Applicant Name:……

Applicant Date of Birth:……

If **YES**, please give date ☐☐☐☐☐☐☐☐ ☐☐☐ and give details in **Section 7**

Please provide if available

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

If **YES**, please give date ☐☐☐☐☐☐☐☐ ☐☐☐ ☐☐☐ and give details in **Section 7**

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Please provide if available

YES **NO**

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

If **YES**, please give date ☐☐☐☐☐☐☐☐ ☐☐☐ and give details in **Section 7**

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Please provide if available

Please proceed to next section 5G

5G Blood Pressure

This section must be completed for all applicants.

YES **NO**

1. Is today's best reading systolic pressure 180mm Hg or greater? ☐ ☐
2. Is today's best reading diastolic pressure 100mm Hg or greater? ☐ ☐
3. Is the applicant on anti-hypertensive treatment? ☐ ☐

If YES, to any of the above, please supply today's best reading and three previous readings with dates, if available.

6 General

Please answer all questions in this section. If your answer is 'YES' to any of the questions, please give full details in Section 7.

YES **NO**

1. Is there **currently** a disability of the spine or limbs, likely to impair control of the vehicle? ☐ ☐

☐ ☐

Applicant Name:……

Applicant Date of Birth:……

2. Is there a history of bronchogenic carcinoma or other malignant tumour, for example, malignant melanoma, with a significant liability to metastasise cerebrally?

   If **YES**, please give dates and diagnosis and state whether there is current evidence of dissemination

	YES	NO
3. Is the applicant profoundly deaf?	☐	☐
If **YES**,		
Is he/she able to communicate in the event of an emergency by speech or by using a device, e.g. a MINICOM/textphone?	☐	☐
4. Is there a history of either renal or hepatic failure?	☐	☐
5. Does the applicant have sleep apnoea syndrome?	☐	☐
(a) Date of diagnosis ☐☐ ☐☐ ☐☐	☐	☐
Is there any other **Medical Condition**, causing excessive daytime sleepiness?	☐	☐

If **YES**, please supply details
If **YES**, please supply details

(b) Is it controlled successfully?

Applicant Name:……

Applicant Date of Birth:……

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

(d) Please state period of control

(e) Please provide neck circumference

(f) Please provide girth measurement in cms

(g) Date last seen by consultant

6.

(a) Diagnosis

Does the applicant have severe symptomatic respiratory disease causing chronic

Does any medication currently taken cause the applicant side effects that could affect safe driving?

If **YES**, please supply details of medication

(b) Date of diagnosis

(c) Is it controlled successfully?

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

(e) Please state period of control

(f) Date last seen by consultant

7. hypoxia?

8.

Applicant Name:……

Applicant Date of Birth:……

	YES	NO
9. Does the applicant have any other medical condition that could affect safe driving?	☐	☐

If **YES**, please supply details

Applicant Name:……

Applicant Date of Birth:……

7 **Please forward copies of relevant hospital notes only. PLEASE DO NOT send any notes not related to fitness to drive.**

Applicant's name **DOB**

Medical Practitioner Details

To be completed by Doctor carrying out the examination

8 **Doctor's Details**

Name
Address
E-mail address
Fax number

Surgery Stamp

Applicant Name:……

Applicant Date of Birth:……

Signature of Medical Practitioner		Date	

Applicant's Details

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

9 Your Details

Your full name	Date of Birth	
Your address	Home telephone number	
	Work/Daytime number	
E-mail address		

About your GP/Group Practice

GP/Group name
GP/Group address
Telephone
E-mail address
Fax number

10 Applicant's consent and declaration

Consent and Declaration

This section **MUST** be completed and must **NOT** be altered in any way.

Applicant Name:……

Applicant Date of Birth:……

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 be a licensed driver, Sheffield City Council may require you to undergo a medical examination or some form of practical assessment. In these circumstances, those personnel involved will require your background medical details to undertake an appropriate and adequate assessment. Such personnel might include doctors, orthoptists at eye clinics or paramedical staff at a driving assessment centre. Only information relevant to the assessment of your fitness to drive will be released. In addition, where the circumstances of your case appear exceptional, the relevant medical information would need to be considered by one or more members of the Sheffield City Council's advisory Panels. The membership of these Panels conforms strictly to the principle of confidentiality.

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 private hire or hackney carriage vehicles, to Sheffield City Council's authorised medical adviser(s).

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 is a criminal offence if I make a false declaration to obtain a driving licence and can lead to prosecution."

Signature…….. Date ……..

Applicant Name:……

Applicant Date of Birth:……