South Lakeland District Council

Medical Examination Form

Medical Examination Report for Hackney Carriage and Private Hire drivers

Group II Medical Examination Report Form

Information notes

It is a requirement under Section 57 of the Local Government (Miscellaneous Provisions) Act 1976 to provide a Medical Examination Report to the effect that you are physically fit to drive a Public, Private Hire or Contract vehicle.

You are required provide a Medical Examination Report to the effect that you are physically fit to hold a Hackney Carriage / Private Hire Driver Licence and is for the confidential use of the Licensing Authority.

This form is to be completed by the applicant's own General Practitioner (GP) or another GP at the same practice, who can confirm they have had full access to the applicant's medical records.

You are required to complete a further Group II Medical Report Form for every Driving Licence renewal (every 3 years) until the age of 65. From the age of 65, a Group II Medical Report Form is required annually.

Any fees charged are payable by the applicant.

- **please use this form to record medical examination details**
- **please complete in block capital letters in black ink**

Licensing Officers are not permitted to complete or amend forms on behalf of applicants.

Note:

Any existing licensed private hire/hackney carriage driver must immediately inform the Council in writing of any deterioration in health or of any injury that would affect his/her ability to drive. (This is in addition to the requirement of Section 94 of the Road Traffic Act 1988 requiring any driver to notify the Secretary of State of any relevant disability).

Guidance notes

What you have to do:

1. Before consulting your GP you may find it helpful to consult the DVLAs "At a Glance" booklet. This is available for download here: www.gov.uk/government/publications/at-a-glance
2. If, after reading the notes, you have any doubts about your ability to meet the medical or eyesight standards, consult your GP/Optician before you arrange for this medical form to be completed as your GP will normally charge you for completing it. In the event of your application being refused, the fee you pay your GP is not refundable. South Lakeland District Council has no responsibility for medical fees.
3. Fill in Section 10 of this report in the presence of the GP carrying out the examination.
4. Application forms must be submitted together with the Group II Medical Report Form otherwise there may be delays in processing your application.

What the GP has to do:

1. Please arrange for the patient to be seen and examined having access to, and regard for, their medical records.
2. Please complete Sections 1-9 and 11 of this report. Please ensure the applicant completes Section 10 in your presence. You may find it helpful to consult the DVLAs "At a Glance" booklet. This is available for download here: www.gov.uk/government/publications/at-a-glance
3. Applicants who may be asymptomatic at the time of the examination are to be advised that, if in future they develop symptoms of a condition which could affect safe driving and they hold either a Hackney Carriage and/ or Private Hire driver licence they must immediately inform the Public Protection (Licensing) Team at South Lakeland District Council. Please record any advice given at Section 6.
4. Please ensure that you have completed all Sections within this form. If this report does not bring out important clinical details which may affect the applicant's fitness to drive, please give details in Section 6.

South Lakeland District Council

Medical Examination Form

Important information for doctors

Please read and follow the information below before deciding if you are able to **fully** and **accurately** fill in the vision assessment. **If you are unable to do this, you must tell the applicant that they will need to ask an optician or optometrist to fill it in.**

We will make a licensing decision based on the information you provide. What you need to assess:

If glasses (not contact lenses) are worn for driving, you MUST be able to establish the dioptre measurement of the correction used. If the correction is greater than +8 dioptres in any meridian of either lens, we may not be able to issue a Group 2 licence.

Applicants (hackney or private hire) must have, as measured by the 6 metre Snellen chart:

- a visual acuity of at least 6/7.5 (decimal Snellen equivalent 0.8) in the better eye
- a visual acuity of at least 6/60 (decimal Snellen equivalent 0.1) in the other eye
- this may be achieved with or without glasses or contact lenses
- we cannot accept a Snellen reading shown with a plus (+) or minus (-) e.g. 6/6-2 or 6/9+3
- 3 metre readings must be converted to the 6 metre equivalent

Before you fill in this report, please:

- check the applicant's identity
- read the information leaflet INF4D (Medical examination report). This can be viewed in PDF format at www.gov.uk/reapply-driving-licence-medical-condition

The applicant is responsible for any fee payable for completion of the assessment. South Lakeland District Council will not be liable for any costs involved.

Please note that if you complete the vision assessment as well as the medical assessment, you must sign and date both parts of the form.

Medical examination report for a Hackney or Private Hire licence

If this form is not fully completed we will return it to you and your application will be delayed.

Your details (applicant)

Name _____

Full address _____

Daytime phone number _____ Date of birth _____

Email address _____

Your doctor's details

Doctor's name _____

Full address _____

Phone number _____ Email address _____

You must sign and date the declaration on page 8 when the doctor and/or optician has completed the report.

This report is valid for 4 months from the date the doctor and/or optician or optometrist signs it. Please return it together with your application form.

Examining doctor's details – to be completed by the doctor carrying out the examination.

Doctor's name _____

Full address _____

Phone number _____ Email address _____

GMC registration number

You must sign and date this form in Section 10. All black outlined boxes MUST be answered. Please make sure all sections of the form have been completed. The form will be returned to you if you don't do this.

Medical examination report

Vision assessment

To be filled in by a doctor or optician/optometrist

If correction is needed to meet the eyesight standard for driving, all questions must be answered. If correction is not needed, questions 5 and 6 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 (see INF4D).

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.

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

3. Is the visual acuity at least 6/7.5 in the better eye and at least 6/60 in the other eye (corrective lenses may be worn to meet this standard)? **Yes** ☐ **No** ☐

4. Were corrective lenses worn to meet this standard? **Yes** ☐ **No** ☐

If **Yes**, glasses ☐ contact lenses ☐ both together ☐

5. If **glasses** (not contact lenses) are worn for driving, is the corrective power greater than plus (+)8 dioptres in any meridian of either lens? **Yes** ☐ **No** ☐

6. If correction is worn for driving, is it well tolerated? **Yes** ☐ **No** ☐

If **No**, please give full details in the box provided

7. Is there a history of any medical condition that may affect the applicant's binocular field of vision (central and/or peripheral)? **Yes** ☐ **No** ☐

If formal visual field testing is considered necessary, DVLA will commission this at a later date

8. Is there diplopia? **Yes** ☐ **No** ☐

(a) If **Yes**, is it controlled? ☐ ☐

If **Yes**, please give full details in the box provided

9. Does the applicant on questioning, report symptoms of intolerance to glare and/or impaired contrast sensitivity and/or impaired twilight vision? **Yes** ☐ **No** ☐

10. Does the applicant have any other ophthalmic condition? **Yes** ☐ **No** ☐

If **Yes** to any of questions 7-10, please give full details in the box provided.

Details/additional information

You must sign and date this section.

Name of examining doctor/optician (print)

Signature of examining doctor/optician

Date of signature D D M M Y Y

Please provide your GOC, HPC or GMC number

Doctor/optometrist/optician's stamp

Applicant's full name _____ **Date of birth** D D M M Y Y

Please do not detach this page

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, page 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 D D M M Y Y		
	Last attack D D M M Y Y		
	(c) Is the applicant currently on anti-epileptic medication? If **Yes,** please fill in current medication in **section 8, page 7**	☐	☐
	(d) If no longer treated, please give date when treatment ended D D M M Y Y		
	(e) Has the applicant had a brain scan? If **Yes,** please give details in **section 6, page 6**	☐	☐
	(f) Has the applicant had an EEG? If **Yes** to any of above, please supply reports if available.	☐	☐
2.	Stroke or TIA?	☐	☐
	If **Yes,** please give date D D M M Y Y		
	Has there been a **FULL** recovery?	☐	☐
	Has a carotid ultra sound been undertaken?	☐	☐
	If **Yes**, was the carotid artery stenosis >50% in either carotid artery?	☐	☐
	Has there been a carotid endarterectomy?	☐	☐
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, page 4
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 D D M M Y Y	☐	☐
	(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, page 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, page 7**	☐	☐
	(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 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.	Is there any evidence of impaired awareness of hypoglycaemia?	☐	☐
4.	Is there a history of hypoglycaemia in the last 12 months requiring the assistance of another person?	☐	☐
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, page 6**	☐	☐
6.	Has there been laser treatment or intra-vitreal treatment for retinopathy? If **Yes**, please give date(s) of treatment.	☐	☐

Applicant's full name _____ **Date of birth** D D M M Y Y

3 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 4**

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, page 6, including dates, period of stability and where appropriate consumption and frequency of use.

4 Cardiac

a Coronary artery disease

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

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.

1. Has the applicant suffered from angina? Yes ☐ No ☐

   If **Yes**, please give the date of the last known attack D D M M Y Y
2. Acute coronary syndrome including myocardial infarction? Yes ☐ No ☐

   If **Yes**, please give date D D M M Y Y
3. Coronary angioplasty (P.C.I.)? Yes ☐ No ☐

   If **Yes**, please give date of most recent intervention D D M M Y Y
4. Coronary artery by-pass graft surgery? Yes ☐ No ☐

   If **Yes**, please give date D D M M Y Y
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 4c**

If **Yes**, please answer **all** questions below and give details in **section 6, page 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 D D M M Y Y

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

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

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 4d**

If **Yes**, please answer **all** questions below and give details in **section 6 page 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? ☐ ☐

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

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

   D D M M Y Y
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

Applicant's full name **Date of birth** D D M M Y Y

d Valvular/congenital heart disease

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

If **No**, go to **section 4e**

If **Yes**, please answer **all** questions below and give details in **section 6 page 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 ☐

e Cardiac other

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

If **No,** go to **section 4f**

If **Yes,** please answer **all** questions and enclose relevant hospital notes.

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 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

☐	D D M M Y Y
☐	D D M M Y Y
☐	D D M M Y Y

g Cardiac investigations

Have any cardiac investigations been undertaken or planned? Yes ☐ No ☐

If **No,** go to **section 5**

If **Yes,** please answer **all** questions

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, page 6.**
2. Has an exercise ECG been undertaken (or planned)? Yes ☐ No ☐
   If **Yes**, please give date and give details in **section 6, page 6** D D M M Y Y
   Please provide relevant reports if available
3. Has an echocardiogram been undertaken (or planned)? Yes ☐ No ☐
   (a) If **Yes**, please give date and give details in **section 6, page 6.** D D M M Y Y
   (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 and give details in **section 6, page 6.** D D M M Y Y
   Please provide relevant reports if available
5. Has a 24 hour ECG tape been undertaken (or planned)? Yes ☐ No ☐
   If **Yes**, please give date and give details in **section 6, page 6.** D D M M Y Y
   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 and give details in **section 6, page 6.** D D M M Y Y
   Please provide relevant reports if available

Applicant's full name ☐ **Date of birth** D D M M Y Y

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 D D M M Y Y

(ii) Is it controlled successfully? **Yes** ☐ **No** ☐

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

(iv) Is applicant compliant with treatment? **Yes** ☐ **No** ☐

(v) Please state period of control

(vi) Date of last review D D M M Y Y

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 D D M M Y Y

7 Consultants' details

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

Consultant in
Name
Address

Date of last appointment D D M M Y Y

Consultant in
Name
Address

Date of last appointment D D M M Y Y

Consultant in
Name
Address

Date of last appointment D D M M Y Y

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

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

Applicant's full name **Date of birth** D D M M Y Y

10. 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

I accept that as part of the investigation into my fitness to drive, South Lakeland District Council may require me to undergo further medical examination or some form of practical assessment. In these circumstances, those personnel involved will require my background medical details to undertake an appropriate and adequate assessment. Such personnel might include doctors, specialist consultants, orthoptists at eye clinics or paramedical staff at a driving assessment centre.

Only information relevant to the assessment of my fitness to drive will be released. In addition, where the circumstances of my case appear exceptional, the relevant medical information may need to be further considered, where such further examination / consideration attracts a cost this will be met by me the applicant, (you will be advised of any further costs as appropriate to determine your application) and where matters of a medical nature exist the application may then be determined by the Councils Licensing Regulatory Committee. (The HC/PH Driver licensing process is managed to strict principles of confidentiality, where applications are to be determined by the Councils Licensing Regulatory Sub-Committee such meetings are held to the exclusion of the press and public).

I authorise my Doctor(s) and Specialist(s) to release report/medical information about my condition, relevant to my fitness to drive, to South Lakeland District Council‟s medical adviser.

I authorise South Lakeland District Council to disclose such relevant medical information as may be necessary to the investigation of my fitness to hold a HC/PH Drivers Licence, to doctors, paramedical, DVLA and to inform my doctor(s) of the outcome of the case where appropriate.

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.

During the period of application and any period when holding a private hire/hackney carriage driver licence, I will immediately inform South Lakeland District Council in writing of any deterioration in health or of any injury or condition that would affect my ability to drive. (This is in addition to the requirement of Section 94 of the Road Traffic Act 1988 requiring any driver to notify the Secretary of State of any relevant disability.

“I understand that it is a criminal offence if I make a false declaration to obtain a private hire / hackney carriage driving licence and can lead to prosecution.”

Signature:		**Date:**	

South Lakeland District Council

Medical Examination Form

General Practitioner Details & Declaration

To be completed by Doctor carrying out the examination.

11. Doctor's details			
Name(s)		Surgery stamp:	
Address			
I certify that I am the named applicant's General Practitioner/a General Practitioner with full access to the applicant's NHS records at the time of the examination **I certify** that I have reviewed all the applicant's medical history and have today examined the named applicant, and I consider him/her FIT ☐ UN-FIT ☐ to act as a hackney carriage/private hire/contract driver in the South Lakeland area. **I declare** that the answers to all questions are true to the best of my knowledge and belief. **I understand** that it is an offence for the person completing this form to make a false statement or omit relevant details.			
I confirm that:			
is registered with this Doctors Practice and I have checked and have had access to their medical history.			
Signature of Medical Practitioner		**Date**	
Print Name of Medical Practitioner		**GP Registered Number**	