Hackney Carriage & Private Hire Driver 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.

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 full medical records 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: https://www.gov.uk/government/publications/assessing-fitness-to-drive-a-guide-for-medical-professionals

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.

The Licensing Section **must** receive this report, together with your application, within 4 months of the doctor signing the report.

- **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: https://www.gov.uk/government/publications/assessing-fitness-to-drive-a-guide-for-medical-professionals

You are advised to obtain the applicant's full 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 section 7.

Patient Name		Date of Birth	

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.

Vision Assessment

To be filled in by a doctor or optician / optometrist

You MUST read the notes shown in the information available at: https://www.gov.uk/government/publications/assessing-fitness-to-drive-a-guide-for-medical-professionals so that you can decide whether you are able to fully complete the vision assessment. Please check the applicant's identity before you proceed.

You must answer ALL the following questions

1. Please confirm (✓) the scale you are using to express the driver's visual acuities.

Snellen ☐ Snellen expressed as a decimal ☐ LogMAR ☐

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.

2. Please provide uncorrected / corrected 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.

	Uncorrected			**Corrected** (using the prescription worn for driving)			
Right	☐	Left	☐	Right	☐	Left	☐

3. What kind of corrective lenses are worn to meet this standard?

Glasses ☐ Contact Lenses ☐ Both together ☐

	Yes	**No**
4. If **glasses** are worn for driving, is the corrective power than plus 8 (+8) dioptres in any meridian of either lens?	☐	☐
5. If a correction is worn for driving is it well tolerated?	☐	☐

If you answered Yes to ANY of the following, give details in the box provided.

6. 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 ensure you give full details in the box below on page 3

7. Is there diplopia?	☐	☐

Patient Name _____ Date of Birth ☐☐☐☐☐☐

(a) Is it controlled?

Patch or glasses with frosted glass

Glasses with/without prism

Other (if other please provide details below)

If **Yes,** please ensure you give full details in the box below.

	Yes	No
8. Does the applicant on questioning report symptoms of any of the following that impairs their ability to drive?		
Intolerance to glare (causing incapacity rather than discomfort)		
Impaired contrast sensitivity		
Impaired twilight vision		
9. Does the applicant have any other ophthalmic condition?		

Details

Date of examination D D M M Y Y

Name (print)

Signature

Date of signature D D M M Y Y

Please provide your GOC, HPC or GMC number

Doctor / optometrist / optician's stamp

Patient Name

Date of Birth

Medical Assessment

This assessment must be filled in by a doctor.

- Please check the applicant's identity before you proceed.
- Please ensure you fully examine the applicant as well as taking the applicant's history.
- **Please answer all questions,** and read the notes available at: https://www.gov.uk/government/publications/assessing-fitness-to-drive-a-guide-for-medical-professionals to help you complete this form

1 Neurological Disorders

	Yes	No
Is there a history or evidence of any neurological disorder? If yes please answer all questions below. If no please go to question 2		

Please tick ✓ the appropriate box(es)	Yes	No
1. Has the applicant had any form of seizure?		
(a) Has the applicant had more than one seizure episode?		
(b) Please give date of first and last episode		

First Episode D D M M Y Y Last Episode D D M M Y Y

(c) Is the applicant currently on anti-epileptic medication?		
(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 7**		
(f) Has the applicant had an ECG?		

If you answered yes to any of the above, you must supply medical reports.

2. Has the applicant experienced dissociative / non-epileptic seizures?		
If yes, please give date of most recent episode (D D M M Y Y)		
If yes, have any of these episode(s) occurred or are they considered likely to occur whilst driving?		
(a) Stroke or TIA		
If **YES**, please give date (D D M M Y Y)		
Has there been a **full** recovery?		

Patient Name _____ Date of Birth _____

Has a carotid ultra sound been undertaken?

If yes, was the carotid artery stenosis >50% in either carotid artery?

Is there a history of multiple strokes / TIA's

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

(c) Subarachnoid haemorrhage (non-traumatic)

(d) Significant head injury within the last 10 years

(e) Any form of brain tumour

(f) Other intracranial pathology

(g) Chronic neurological disorders

(h) Parkinson's disease

(i) Blackout, impaired consciousness or loss or awareness within the last 10 years.

2 Diabetes Mellitus

	Yes	No
1. Does the applicant have diabetes mellitus? If **NO**, please go 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 D D M M Y Y		
(b) Are there at least 3 continuous months of blood glucose readings stored on a memory meter(s)? If **NO**, please give details in **section 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 give details:

(f) Diet only?

3. (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?

4. Has the applicant ever had a hypoglycaemic episode?

If yes, is there full awareness of hypoglycaemia?

5. Is there a history of hypoglycaemia 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 7**

7. Has there been laser treatment or intra-vitreal treatment for retinopathy?

If **YES,** please give date(s) of treatment.

3 Psychiatric Illness

	Yes	No
Is there a history or evidence of psychiatric illness within the last 3 years?		

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

- If applicant remains under specialist clinic(s), ensure details are filled in at **section 7**

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

If **YES,** please confirm condition.

2. Psychosis or hypomania / mania within the past 12 months, including psychotic depression

3. Dementia or cognitive impairment

   Are there concerns which have resulted in ongoing investigations for such possible diagnoses?

4. Is there a history of drug / alcohol misuse or dependence?

If yes, please answer the following questions.

5. Is there a history of alcohol dependence in the past 6 years?

   Is it controlled?

   Has the applicant undergone an alcohol detoxification programme?

   If **YES**, please give date started D D M M Y Y

6. Persistent alcohol misuse in the past 3 years?

   Is it controlled?

7. Persistent misuse of drugs or other substances in the past 6 years?

If **YES,** the type of substance misused?

   Is it controlled?

   Has the applicant undertaken an opiate treatment programme?

   If **YES**, please give date started D D M M Y Y

4 Cardiac

4A Coronary Artery Disease

	Yes	No
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 7** of the form.		

Patient Name

Date of Birth

1. Has the applicant ever had an episode of Angina?

   If **YES**, please give date of the last known attack D D M M Y Y

2. Acute coronary syndromes including Myocardial infarction?

   If **YES**, please give date D D M M Y Y

3. Coronary angioplasty (PCI)?

   If **YES**, please give date of most recent intervention D D M M Y Y

4. Coronary artery by-pass graft surgery?

   If **YES**, please give date D D M M Y Y

If yes, to any of the above, are there any physical health problems or disabilities (e.g. mobility, arthritis or COPD) that would make the applicant unable to undertake 9 minutes of the standard Bruce Protocol ETT? Please give details below:

4B Cardiac Arrhythmia

	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 in **section 7**		
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 (Implanted Cardiac Defibrillator) or biventricular pacemaker with defibrillator / cardiac resynchronisation therapy defibrillator (CRT-D type) been implanted?		
4. Has a pacemaker or a biventricular pacemaker / cardiac resynchronisation therapy pacemaker (CRT-P) been implanted?		

If **YES**:-

(a) Please give date of implantation D D M M Y Y

(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

Is there a history or evidence of peripheral arterial disease (excluding Buerger's disease), aortic aneurysm or dissection?
If **NO**, go to **section 4D**. If **YES**, please answer all questions below and give details in **section 7**

1. Peripheral arterial disease (excluding Buerger's Disease)
2. Does the applicant have claudication?

   If **YES**, would the applicant be able to undertake 9 minutes of the standard Bruce Protocol ETT?
3. Aortic Aneurysm
   If **YES**:

   (a) Site of Aneurysm: Thoracic Abdominal

   (b) Has it been repaired successfully?

   (c) Please provide the latest transverse aortic diameter measurement and date obtained below

D D M M Y Y

4. Dissection of the aorta repaired successfully? (If yes, please provide copies of all reports including those dealing with any surgical treatment)
5. Is there a history of Marfan's disease? (If yes, please provide relevant hospital notes)

4D Valvular / Congenital Heart Disease

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 in **section 7** of the form

1. Is there a history of congenital heart disease?
2. Is there a history of heart valve disease?

Patient Name

Date of Birth

3. Is there a history of aortic stenosis?
   (If yes, please provide relevant reports including echocardiogram)

4. Is there any history of embolic stroke?

5. Does the applicant currently have significant symptoms?

6. Has there been any progression, either clinically or on scans etc, since the last licence application?

4E Cardiac Other

Does the patient 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 7**

Yes **No**

(a) a history of, or evidence of, heart failure?

Please provide the NYHA class, if known.

(b) established cardiomyopathy?

(c) has a left ventricular assist device (LVAD) or other cardiac assist device been implanted?

(d) a heart or heart / lung transplant?

(e) untreated atrial myxoma

Is there any history or evidence of the following conditions?

Yes **No**

Brugada Syndrome

Yes **No**

Long QT Syndrome

If no go to 4F, if yes please give details and enclosed relevant hospital notes.

4F Cardiac Investigations (this section must be filled in for all applicants)

	Yes	No
1. Have any cardiac investigations been undertaken or planned?		
2. 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 relevant ECG report and comments at section 7.

3. Has an exercise ECG been undertaken (or planned)?		
If **YES**, please give date and give details in **section 7**	D D M M Y Y	
4. Has an echocardiogram been undertaken (or planned)?		
(a) If **YES**, please give date and give details in **section 7**	D D M M Y Y	
(b) If undertaken, is / was the left ejection fraction greater than or equal to 40%.		
5. Has a coronary angiogram been undertaken (or planned)?		
If **YES**, please give date and give details in **section 7**	D D M M Y Y	
6. Has a 24 hour ECG tape been undertaken (or planned)		
If **YES**, please give date and give details in **section 7**	D D M M Y Y	
7. Has a loop recorder been implanted (or planned)		
If **YES**, please give date and give details in **section 7**	D D M M Y Y	
8. Has a myocardial perfusion scan, stress echo study or cardiac MRI been undertaken (or planned)?		
If **YES**, please give date and give details in **section 7**	D D M M Y Y	

4G Blood Pressure

If resting blood pressure is 180 mm/Hg systolic or more and/or 100 mm/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 blood pressure reading

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

If **YES** 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

3. Is there a history of malignant hypertension? **Yes** **No**
   If yes, please give details below

5 General

Please answer **ALL** questions. If **YES** to any give full details in **section 7**.

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 below and answer the following questions.

(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 answer questions (i) to vi) for **all sleep** conditions.

(i) Date of diagnosis D D M M Y Y

	Yes	No
(ii) Is it controlled successfully?		

If yes please state treatment.

(iii) Is the applicant compliant with treatment?

Please state period of control

Years	Months

Date of last review D D M M Y Y

	Yes	No
2. Is there a history or evidence of narcolepsy?		
3. Is there currently any functional impairment that is likely to affect control of the vehicle?		
4. Is there a history of bronchogenic carcinoma or other malignant tumour with a significant liability to metastasise cerebrally?		
5. Is there any illness that may cause significant fatigue or cachexia that affects safe driving?		
6. 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 textphone?		
7. Does the applicant have a history of liver disease of any origin?		
If yes, is this a result of alcohol misuse? (give details below)		
8. Is there a history or renal failure? (give details below)		

Patient Name

Date of Birth

9. Does any medication currently taken cause the applicant side effects that could affect safe driving? (give details below)

10. Does the applicant have any other medical condition that could affect safe driving?. (give details below)

6 Medication

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

Medication	
Dosage	
Reason for Taking	
Approximate Date Started (if known)	

Medication	
Dosage	
Reason for Taking	
Approximate Date Started (if known)	

Medication	
Dosage	
Reason for Taking	
Approximate Date Started (if known)	

Medication	
Dosage	
Reason for Taking	
Approximate Date Started (if known)	

7 Further details

8 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

Patient Name

Date of Birth

Consultant in

Name

Address

Date of last appointment D D M M Y Y

9 Additional Information

Patient's weight (kg)

Height (cms)

Details of smoking habits, if any

Number of alcohol units taken each week

10 Doctors details (please print name and address in capital letters)

To be filled in by doctor carrying out the examination.

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

I certify that the applicant named in this medical ✓:-

- **Meets the DVLA group 2** medical standards
- **DOES NOT meet the DVLA group 2** medical standards

****Please ensure you, the GP / approved medical provider, confirm if you have referred to the full medical records of the applicant, when carrying out the examination. Failure to do so will result in the form being rejected.****

I have referred to the **applicant's medical records** in my completion of this report.

OR

I have referred to **a summary of the applicant's medical records** in my completion of this report.

Patient Name

Date of Birth

Name	
Address	
Telephone	
Email	

Surgery Stamp or
GMC Registration Number

GMC registration number

Signed

Date of Examination

11 Your Details

To be filled-in 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 submitting this form with your application for a licence to drive private hire / hackney carriage vehicles.

Name	
Address	
Date of Birth	
Telephone Number(s)	
Email Address	

About your GP / Group Practice

GP / Group Name	
Address	
Phone	
Email Address	
Fax Number	

Patient Name

Date of Birth

12 Applicants Declaration

I authorise my doctor(s) to release information / reports to Trafford Council's Licensing Officer about my medical condition.

I declare that I have checked the details I have given in this report 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 and can lead to prosecution.

Signed	
Date	