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| **MEDICAL ASSESSMENT**  **ASSO****CIATED WITH AN APPLICATION FOR A LICENCE TO DRIVE A HACKNEY CARRIAGE OR PRIVATE HIRE VEHICLE**  **Notes for the Applicant**  This medical examination now includes a vision assessment that must be filled in by a doctor or optician/optometrist. Some doctors will be able to fill in both vision and medical assessment section of the report. If your doctor is unable to fully answer all of the questions on the vision assessment you must have it filled in by an optician/optometrist. If you do not wear glasses to meet the eyesight test standard or if you have a minus (-) eyesight prescription, your doctor may be able to fill in the whole report. If you wear  glasses and you have asked a doctor to fill in the report you must take your current prescription to the  assessment.  The Council is not responsible for any fees that you may pay to a doctor and or optician/optometrist and or other medical specialist, even if you are unable to meet the Group 2 medical fitness to driver standard**.**  **You must take a form of photographic identity to the examination, for example your passport or DVLA driving licence**   * All new driver applications are subject to a full Group II Medical Assessment completed by a GP at the surgery where the applicant is registered. * Any driver renewing a licence is subject to a further medical every five years until they reach the age of 65 then annually if they continue to hold a licence.   **General**  An applicant/driver with an on-going medical condition, ie diabetes, which is controlled by insulin, or has a heart condition, will be required to provide the Council with details of any change in that condition or in their medication.  During the life of a licence;   1. a driver diagnosed with a new medical condition or 2. a driver who has an existing condition which develops (and may affect their ability to drive)   is required to inform Taxi Licensing Section immediately. In these circumstances a further Medical may be required. Licence renewals will not be processed where a Medical Assessment has not been received. Applicants/drivers should ensure that they have allowed plenty of time to book GP appointment(s). | | |
| **Applicant’s details: (to be filled in the presence of the doctor carrying out the examination)** | | |
| First name(s):  Surname: | Date of birth:  Age: |  |
| **Current address:**  **Post Code:**  **Contact telephone number:** | |

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| **Applicant’s consent and declaration:**  **(Please read the following carefully before signing and dating the declaration).**  **I authorise my General Practitioner(s) and Specialist(s) to release medical information about my condition, together with any relevant information relevant to fitness to drive, to the Taxi Licensing Section of Guildford Borough Council for the purpose of the Council (by its Officers and/or Members) of assessing my fitness to drive a hackney carriage or private hire vehicle licensed by that Council.**  **I declare that to the best of my knowledge and belief all information given by me to my doctors in connection with the examination or completion of the DVLA Group 2 medical examination report are true. In the event that the Council is not satisfied of my fitness to drive a hackney carriage or private hire vehicle.**  **I confirm that if I wish to do so, I may, at my own cost, submit further medical evidence to the Council as I consider appropriate.** | |
| **Signed:** | **Date:** |

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| **General Practitioner**  **This form must be completed in full by the applicant’s own General Practitioner.**  **Please answer all questions and once completed sign the declaration at the end.**  **The Councils’ policy on medical fitness requires that taxi drivers meet Group 2 Entitlement, as set out in the DVLA publication ‘*A Guide to the current Medical Standards of Fitness to Drive*’.**  **This guide makes reference to current best practice guidance contained in the booklet ‘Fitness to**  **Drive’ which recommends the medical standard applied by DVLA in relation to bus and lorry drivers should also be applied by local authorities to taxi drivers.** | | | |
| **(a)** | **Is the applicant a registered patient of the surgery / medical centre at which you practice as a registered medical practitioner?** | **YES** | **NO\*** |
| **(b)** | **Have you reviewed the above applicant’s medical records?**  **If reviewing a printout of the medical records please give date of print out:** | **YES** | **NO** |

**\*IF THE PATIENT IS NOT REGISTERED AT YOUR SURGERY AND YOU ARE REVIEWING A PRINTED HISTORY OF HIS/HER MEDICAL RECORDS – PLEASE ENCLOSE THE FULL COPY OF THE PRINTED HISTORY YOU HAVE SEEN, WITH THIS DOCUMENT.**

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| **1** | **Vision Assessment – to be completed by the GP or optician/optometrist**  **Note: you must read the current DVLA guidance so that you can decide whether you are able to fully complete the vision assessment at**  [**www.gov.uk/current-medical-guidelines-dvla-guidance-for-**](http://www.gov.uk/current-medical-guidelines-dvla-guidance-for-professionals)[**professionals**](http://www.gov.uk/current-medical-guidelines-dvla-guidance-for-professionals) | | | | | | | | | | | | | |
|  | **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. (Corrective lenses may be worn)** | | | | | | | | | | | | | |
| **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** | | | | | | | | | | | | | |
|  | **Uncorrected** | | | | | **Corrected (using the prescription worn for driving)** | | | | | | | | |
|  | **Right** | | | **Left** | | **Right** | | | **Left** | | | | | |
| **3.** | **Please give the best binocular acuity with corrective lenses if worn for driving** | | | | | | | | | |  | | | |
| **4.** | **If glasses were worn, was the distance spectacle prescription of either lens used of a corrective power greater than plus 8(+8) dioptres?** | | | | | | | | | | **Yes** | | **No** | |
| **5.** | **If a correction is worn for driving, is it well tolerated?** | | | | | | | | | | **Yes** | | **No** | |
| **6.** | **Is there a history of any medical condition that may affect the applicant’s binocular field of vision (central and /or peripheral)?**  **If formal visual field testing** | | | | | | | | | | **Yes** | | **No** | |
|  | **(c)** | **Correction well tolerated?** | | | | | | | | | **Yes** | | **No** | |
| **iii** | **Please state the visual acuity of each eye** | | | | | | | | | |  | |  | |
|  | **Uncorrected** | | | | **Corrected (using the prescription worn for driving)** | | | | | |  | | | |
|  | **Right** | | **Left** | | **Right** | | **Left** | | | |  | | | |
| **iv** | **Is there a defect in the patient’s binocular field of vision (central and/or peripheral)?** | | | | | | | | | | **Yes** | | **No** | |
| **v** | **Is there diplopia (controlled or uncontrolled)?** | | | | | | | | | | **Yes** | | **No** | |
| **vi** | **Does the patient have any other ophthalmic condition?**  **If YES to questions 4, 5 or 6 please give details in Section 9.** | | | | | | | | | | **Yes** | | **No** | |
| **In relation to section 1 does the applicant meet the DVLA Group II medical conditions?** | | | | | | | | **YES** | |  | | **NO** | |  |
| **If not please indicate reasons why** | | | | | | | | | | | | | | |
| **If eye examination has been completed by an optician/optometrist please give details below**  **Name:**  **Address:**  **Contact telephone number:** | | | | | | | | | | | | | | |

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| **2** | **NERVOUS SYSTEM** | | | | | | | | | | | | | | |
| **i** | **Has the patient had any form of epileptic attack?**  **If YES, please answer questions a – f below** | | | | | | | | | | | **YES** | | **NO** | |
|  | **(a)** | **Has the patient had more than one attack?** | | | | | | | | | | **Yes** | | **No** | |
|  | **(b)** | **Please give date of first and last attack:** | | **First**  **attack** | |  | | **Last attack** | |  | |  | |  | |
|  | **(c)** | **Is the patient currently on anti-epilepsy medication?**  **If YES, please give details of current medication:** | | | | | | | | | | **Yes** | | **No** | |
|  | **(d)** | **If treated, please give date when treatment ended:** | | | | | | | | | | | | | |
|  | **(e)** | **Has the patient had a brain scan? If YES, please state dates:** | | | | | | | | | | **Yes** | | **No** | |
|  |  | **MRI** |  | | **CT** | |  | | | | |  | |  | |
|  | **(f)** | **Has the patient had an EEG?**  **If YES, please provide date and details** | | | | | | | | | | **Yes** | | **No** | |
| **ii** | **Is there a history of blackout or impaired consciousness within the last 5 years? If YES, please give dates and details at Section 9.** | | | | | | | | | | | **Yes** | | **No** | |
| **iii** | **Is there a history of, or evidence of, any of the conditions listed at a – g below? If NO, go to Section 3.** | | | | | | | | | | | **Yes** | | **No** | |
|  | **If YES, please answer the following questions and give dates and full details.** | | | | | | | | | | |  | | | |
|  | **(a)** | **Stroke / TIA (*please delete as appropriate*)**  **If YES, please give date:** | | | | | | | | | | **Yes** | | **No** | |
|  |  | **Has there been a full recovery?** | | | | | | | | | | **Yes** | | **No** | |
|  | **(b)** | **Sudden and disabling dizziness/vertigo within the last one year with a liability to recur** | | | | | | | | | | **Yes** | | **No** | |
|  | **©** | **Subarachnoid hemorrhage** | | | | | | | | | | **Yes** | | **No** | |
|  | **(d)** | **Serious head injury within the last 10 years** | | | | | | | | | | **Yes** | | **No** | |
|  | **(e)** | **Brain tumour, either benign or malignant, primary or secondary** | | | | | | | | | | **Yes** | | **No** | |
|  | **(f)** | **Other brain surgery/abnormality** | | | | | | | | | | **Yes** | | **No** | |
|  | **(g)** | **Chronic neurological disorders e.g. Parkinson’s disease, Multiple Sclerosis** | | | | | | | | | | **Yes** | | **No** | |
| **In relation to section 2 does the applicant meet the DVLA Group II medical conditions?** | | | | | | | | | **YES** | |  | | **NO** | |  |
| **If not please indicate reasons why** | | | | | | | | | | | | | | | |

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| **3** |  |  | **DIABETES MELLITUS** |  |  |
| **i** | **Does the patient have diabetes mellitus?**  **If NO, please go to Section 4.**  **If YES, please FULLY COMPLETE SECTION 3.** | | | **Yes** | **No** |
| **ii** | **Is the diabetes managed by:** | |  |  |  |
|  | **(a)** | **Insulin?**  **If YES, please give date started on insulin AND CONFIRM THAT THE STANDARDS FOR INSULIN TREATED DRIVERS ARE MET – SEE BELOW**  **(The licence application process cannot start until an applicant’s condition has been stable for at least one month and they can provide two months of blood glucose readings whilst on insulin.)** | | **Yes** | **No** |
|  | **(b)** | **Exenatide/Byetta?** |  | **Yes** | **No** |
|  | **(c)** | **Oral hypoglycaemic agents and diet?**  **If YES, please provide details of medication:** | | **Yes** | **No** |
|  | **(d)** | **Diet only?** |  | **Yes** | **No** |
| **iii** | **Does the patient test blood glucose at least twice every day? (see note below)** | | | **Yes** | **No** |
| **For diabetics treated with INSULIN the following criteria must be met:**  **(There is a legal requirement for Group 2 drivers to monitor their blood glucose for the purpose of Group 2 driving. Flash GM and RT-CGM interstitial fluid glucose monitoring is not permitted for Group 2 driving and licensing. Group 2 drivers who use these devices must continue to monitor fingerprint capillary blood glucose levels with the regularity defined below.)**   |  |  |  | | --- | --- | --- | | * **practices blood glucose testing – at least twice daily, including days when not driving; and** * **no more than 2 hours before the start of the first journey; and** * **every 2 hours after driving has started** * **A maximum of 2 hours between the pre-driving glucose test and the first glucose check performed after driving has started** | **Yes** | **No** | | **Yes** | **No** | | **Yes** | **No** | | **Yes** | **No** | | * **must use a blood glucose meter with sufficient memory to store three months of readings** | **Yes** | **No** | | * **the applicant’s usual doctor who provides diabetes care to undertake an examination at least every three years to include review of the previous three months glucose readings** | **Yes** | **No** | | * **arranges an examination to be undertaken every 12 months by an independent consultant specialist in diabetes if the examination by their usual doctor is satisfactory (please attach latest report)** | **Yes** | **No** | | * **full awareness of hypoglycaemia** | **Yes** | **No** | | * **demonstrates an understanding of the risks of hypoglycaemia** | **Yes** | **No** | | * **no episode of severe hypoglycaemia in the preceding 12 months** | **Yes** | **No** | | * **has no disqualifying complications of diabetes that mean a licence will be refused or revoked, such as visual field defect** | **Yes** | **No** |   **If the medical standards are met, a 1, 2 or 3 year licence will be issued.** | | | | | |
| **For diabetics treated by medication other than insulin and carrying risks of hypoglycaemia the following criteria must be met:**   |  |  |  | | --- | --- | --- | | * **full awareness of hypoglycaemia** | **Yes** | **No** | | * **no episode of severe hypoglycaemia in the preceding 12 months** | **Yes** | **No** | | * **practices regular self-monitoring of blood glucose– at least twice daily and at times relevant to driving (ie, no more than 2 hours before the start of the first journey and every 2 hours whilst driving)** | **Yes** | **No** | | * **demonstrates an understanding of the risks of hypoglycaemia** | **Yes** | **No** | | * **has no qualifying complications of diabetes that mean a licence will be refused or revoked, such as visual field defect** | **Yes** | **No** |   **If the medical standards are met, a 1, 2 or 3 year licence will be issued.** | | | | | |

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| **iv** | **Is there evidence of:-** | | | |  | |  | |
|  | **(a)** | **Loss of visual field?** | | | **Yes** | | **No** | |
|  | **(b)** | **Severe peripheral neuropathy, sufficient to impair limb function for safe driving?** | | | **Yes** | | **No** | |
|  | **(c)** | **Diminished / Absent awareness of hypoglycaemia?** | | | **Yes** | | **No** | |
| **v** | **Has there been any laser treatment for retinopathy?**  **If YES, please give date(s) of treatment** | | | | **Yes** | | **No** | |
| **vi** | **Is there a history of hypoglycaemia during waking hours in the last 12 months requiring assistance?** | | | | **Yes** | | **No** | |
|  | **If YES to any of 4 – 6 above please give details in Section 9.** | | | | | | | |
| **In relation to section 3 does the applicant meet the DVLA Group II medical conditions?** | | | **YES** |  | | **NO** | |  |
| **If not please indicate reasons why** | | | | | | | | |

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| **4** | **PSYCHIATRIC ILLNESS** | | | | | | |
|  | **Is there a history of, or evidence of any of the conditions listed at 1 – 7 below? If NO, please go to Section 5.** | | | **YES** | | **NO** | |
|  | **If YES please answer the following questions and give date(s), prognosis, period of stability and details of medication, dosage and any side effects in Section 9. (Please enclose relevant notes - If patient remains under specialist clinic(s) and give full details in Section 9 especially if the applicant is on prescribed medication ).** | | | | | | |
| **i** | **Psychiatric disorder within the past 6 months?** | | | **Yes** | | **No** | |
| **ii** | **A psychotic illness within the past 3 years, including psychotic depression?** | | | **Yes** | | **No** | |
| **iii** | **Dementia or cognitive impairment?** | | | **Yes** | | **No** | |
| **iv** | **Persistent alcohol misuse in the past 12 months?** | | | **Yes** | | **No** | |
| **v** | **Alcohol dependency in the past 3 years?** | | | **Yes** | | **No** | |
| **vi** | **Persistent drug misuse in the past 12 months?** | | | **Yes** | | **No** | |
| **vii** | **Drug dependency in the past 3 years?** | | | **Yes** | | **No** | |
| **In relation to section 4 does the applicant meet the DVLA Group II medical conditions?** | | **YES** |  | | **NO** | |  |
| **If not please indicate reasons why** | | | | | | | |
| **5** | **CARDIAC \* (Please read notes below)** | | | | | | |
|  | **Is there a history of, or evidence of, Coronary Artery Disease? If NO, please go to Section 5B.**  **If YES, please answer all questions below and give details at Section 9 of the form.** | | | **YES** | | **NO** | |
| **5A** | **CORONARY ARTERY DISEASE** | | | | | | |
| **i** | **Acute Coronary Syndromes including Myocardial Infarction? If YES please give date(s):** | | | **Yes** | | **No** | |
| **ii** | **Coronary artery by-pass graft surgery? If YES please give date(s):** | | | **Yes** | | **No** | |
| **iii** | **Coronary Angioplasty (P.C.I.)?**  **If YES please give date of most recent intervention:** | | | **Yes** | | **No** | |
| **iv** | **Has the patient suffered from Angina?**  **If YES please give the date of the last attack:** | | | **Yes** | | **No** | |
| **In relation to section 5A does the applicant meet the DVLA Group II medical conditions?** | | **YES** |  | | **NO** | |  |
| **If not please indicate reasons why**  **\* If a patient has established coronary heart disease evidence is required in the form of an exercise ECG, or stress myocardial profusion scan/stress echocardiogram. These tests must be completed every three years in accordance with Appendix C, Assessing fitness to drive. A guide for medical professionals. Please see** [**https://www.gov.uk/government/publications/assessing-fitness-to-drive-a-guide-for-medical-professionals**](https://www.gov.uk/government/publications/assessing-fitness-to-drive-a-guide-for-medical-professionals) **Applicants/Drivers cannot meet the requirements without these tests.** | | | | | | | |
| **Please go to next Section 5B** | | | | | | | |

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| **5B** | **CARDIAC ARRHYTHMIA** | | | | | | | |
|  | **Is there a history of, or evidence of, cardiac arrhythmia? If NO, go to Section 5C.**  **If YES, please answer all questions below and give details in Section 9.** | | | | **YES** | | **NO** | |
| **i** | **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?** | | | | **Yes** | | **No** | |
| **ii** | **Has the arrhythmia been controlled satisfactorily for at least 3 months?** | | | | **Yes** | | **No** | |
| **iii** | **Has an ICD or biventricular pacemaker (CRST-D type) been implanted?** | | | | **Yes** | | **No** | |
| **iv** | **Has a pacemaker been implanted? If YES:** | | | | **Yes** | | **No** | |
|  | **(a)** | **Please supply date:** | | | | | | |
|  | **(b)** | **Is the patient free of symptoms that caused the device to be fitted?** | | | **Yes** | | **No** | |
|  | **(c)** | **Does the patient attend a pacemaker clinic regularly?** | | | **Yes** | | **No** | |
| **In relation to section 5B does the applicant meet the DVLA Group II medical conditions?** | | | **YES** |  | | **NO** | |  |
| **If not please indicate reasons why** | | | | | | | | |
| **Please go to next Section 5C** | | | | | | | | |

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| **5C** | **PERIPHERAL ARTERIAL DISEASE (EXCLUDING BUERGER’S DISEASE) AORTIC ANEURYSM/DISSECTION** | | | | | | | |
|  | **Is there a history or evidence of ANY of the following? If NO go to Section 5D.**  **If YES please answer the questions below and give details in Section 9.** | | | | | | **YES** | **NO** |
| **i** | **Peripheral Arterial Disease (excluding Buerger’s Disease)** | | | | | | **Yes** | **No** |
| **ii** | **Does the patient have claudication?**  **If YES please give details as to how long in minutes the patient can walk at a brisk pace before being symptom limited:** | | | | | | **Yes** | **No** |
| **iii** | **Aortic aneurysm? YES:**  **Note: the exercise or other functional test requirements will need to be met in all cases of abdominal aortic aneurysm irrespective of the diameter** | | | | | |  |  |
|  | **(a)** | **Site of Aneurysm (please tick):** | **Thoracic** | **Abdominal** | | |  |  |
|  | **(b)** | **Has it been repaired successfully?** | | | | | **Yes** | **No** |
|  | **(c)** | **Is the transverse diameter currently >5.5 cms?** | | | | | **Yes** | **No** |
|  |  | **If NO, please provide latest measurement:** | | **Date obtained:** | | |  |  |
| **iv** | **Dissection of the aorta repaired successfully?**  **If YES, please provide details** | | | | | | **Yes** | **No** |
| **In relation to section 5C does the applicant meet the DVLA Group II medical conditions?** | | | | | **YES** |  | **NO** |  |
| **If not please indicate reasons why** | | | | | | | | |
| **Please go to next Section 5D** | | | | | | | | |

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| **5D** | **VALVULAR/CONGENITAL HEART DISEASE** | | | |  |  |
|  | **Is there a history of, or evidence of, valvular/congenital heart disease?** | | | | **Yes** | **No** |
|  | **If NO, go to Section 5E.**  **If YES, please answer all questions below and give details in Section 9 of the form** | | | |  |  |
| **i** | **Is there a history of congenital heart disorder?** | | | | **Yes** | **No** |
| **ii** | **Is there a history of heart valve disease?** | | | | **Yes** | **No** |
| **iii** | **Is there any history of embolism? (not pulmonary embolism)** | | | | **Yes** | **No** |
| **iv** | **Does the patient currently have significant symptoms?** | | | | **Yes** | **No** |
| **v** | **Is there a history of, aortic stenosis?**  **If Yes, please provide relevant reports.** | | | | **Yes** | **No** |
| **vi** | **Has there been any progression since the last licence application? (if relevant)** | | | | **Yes** | **No** |
| **In relation to section 5D does the applicant meet the DVLA Group II medical conditions?** | | | **YES** |  | **NO** |  |
| **If not please indicate reasons why** | | | | | | |
| **5E** | **CARDIAC OTHER** | | | | | |
|  | **Does the patient have a history of ANY of the following conditions? If NO go to Section 5F**  **If YES please answer all questions below and give details in Section 9 of the form** | | | | **YES** | **NO** |
|  | **(a)** | **A history of, or evidence of, heart failure?** | | | **Yes** | **No** |
|  | **(b)** | **Established cardiomyopathy?** | | | **Yes** | **No** |
|  | **(c)** | **A heart or heart/lung transplant?** | | | **Yes** | **No** |
|  | **(d)** | **Has a left ventricular assist device (LVAD) been implanted?** | | | **Yes** | **No** |
| **In relation to section 5E does the applicant meet the DVLA Group II medical conditions?** | | | **YES** |  | **NO** |  |
| **If not please indicate reasons why** | | | | | | |
| **5F** | **CARDIAC INVESTIGATIONS (This section must be filled in for all patients)** | | | | | |
| **i** | **Has a resting ECG been undertaken?**  **If YES, does it show:** | | | | **YES** | **NO** |
|  | **(a)** | **Pathological Q waves?** | | | **Yes** | **No** |
|  | **(b)** | **Left bundle branch block?** | | | **Yes** | **No** |
|  | **(c)** | **Right bundle branch block?** | | | **Yes** | **No** |
| **ii** | **Has the exercise ECG been undertaken (or planned)?** | | | | **Yes** | **No** |
|  | **If YES please provide date and give details in Section 9:** | | | |  |  |
| **iii** | **Has an echocardiogram been undertaken (or planned)?** | | | | **Yes** | **No** |
|  | **(a)** | **If YES please give date and give details in Section 9:** | | |  |  |
|  | **(b)** | **If undertaken is/was the left ventricular ejection fraction greater than or equal to 40%?** | | | **Yes** | **No** |
| **iv** |  | **Has a coronary angiogram been undertaken (or planned)?**  **If YES, please provide date and give details in Section 9:** | | | **Yes** | **No** |
| **v** |  | **Has a 24 hour ECG tape been undertaken (or planned)?**  **If YES, please provide date and give details in Section 9:** | | | **Yes** | **No** |
| **vi** |  | **Has a Myocardial Perfusion Scan or Stress Echo study been undertaken (or planned)?**  **If YES, please provide date and give details in Section 9:** | | | **Yes** | **No** |

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| **In relation to section 5F does the applicant meet the DVLA Group II medical conditions?** | | | **YES** |  | **NO** |  |
| **If not please indicate reasons why** | | | | | | |
| **Please go to next Section 5G** | | | | | | |
| **5G** | **BLOOD PRESSURE (This section must be filled in for all patients)** | | | | | |
| **i** | **Is today’s best systolic pressure reading 180 mm/Hg or more? (Please give reading)**  **BP reading:** | | | | **Yes** | **No** |
| **ii** | **Is today’s best diastolic pressure reading 100mm Hg or more? (Please give reading)**  **BP reading:** | | | | **Yes** | **No** |
| **iii** | **Is the patient on anti-hypertensive treatment?** | | | | **Yes** | **No** |
|  | **If YES to any of the above please provide three previous readings with dates if available:** | | | |  |  |
|  | **1. B.P reading:** | **Date:** | | | | |
|  | **2. B.P reading:** | **Date:** | | | | |
|  | **3. B.P reading:** | **Date:** | | | | |
| **In relation to section 5G does the applicant meet the DVLA Group II medical conditions?** | | | **YES** |  | **NO** |  |
| **If not please indicate reasons why** | | | | | | |

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| **6.** | **GENERAL**  **Please answer all questions in this section.**  **If your answer is YES to any question please give full details in Section 9.** | | | | | | | |
| **i** | **Is there currently a disability of the spine or limbs likely to impair control of the vehicle?** | | | | | | **Yes** | **No** |
| **ii** | **Is there a history of bronchogenic carcinoma or other malignant tumour, for example, malignant melanoma, with a significant liability to metastasise? cerebrally?** | | | | | | **Yes** | **No** |
|  | **If YES please give dates and diagnosis and state whether there is current evidence of dissemination?** | | | | | |  |  |
|  | **(a)** | **Is there any evidence the patient has a cancer that causes fatigue or cachexia that affects safe driving?** | | | | | **Yes** | **No** |
| **iii** | **Is the patient profoundly deaf?** | | | | | | **Yes** | **No** |
|  | **If YES is the patient able to communicate in the event of an emergency by speech or by using a device e.g. a text/phone?** | | | | | | **Yes** | **No** |
| **iv** | **Is there a history of either renal or hepatic failure?** | | | | | | **Yes** | **No** |
| **v** | **Is there a history of, or evidence of sleep apnoea syndrome?** | | | | | | **Yes** | **No** |
|  | **If YES please indicate severity**  **Mild (AHI <15)**  **Moderate (AHI 15 – 29)**  **Severe (AHI >29)**  **Not known** | | | | | |  |  |
|  | **(a)** | **Date of diagnosis:** | | | | | | |
|  | **(b)** | **Is it controlled successfully?** | | | | | **Yes** | **No** |
|  | **(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:** | | | | | | |
| **vi** | **Does the patient suffer from narcolepsy/cataplexy?** | | | | | | **Yes** | **No** |
| **vii** | **Is there any other Medical Condition causing daytime sleepiness?** | | | | | | **Yes** | **No** |
|  | **If YES please provide details:** | | | | | |  |  |
|  | **(a)** | **Diagnosis:** | | | | |  |  |
|  | **(b)** | **Date of diagnosis:** | | | | |  |  |
|  | **(c)** | **Is it controlled successfully?** | | | | | **Yes** | **No** |
|  | **(d)** | **If YES please state treatment:** | **(e) Please state period of control:** | | | | | |
|  | **(f)** | **Date last seen by consultant:** | | | | | | |
| **viii** | **Does the patient have severe symptomatic respiratory disease causing chronic hypoxia?** | | | | | | **Yes** | **No** |
| **ix** | **Does any medication currently taken cause the patient side effects that could affect safe driving?** | | | | | | **Yes** | **No** |
|  | **If YES please provide details:** | | | | | |  |  |
| **x** | **Does the patient have any other medical condition that could affect safe driving?** | | | | | | **Yes** | **No** |
|  | **If YES please provide details:** | | | | | |  |  |
| **In relation to section 6 does the applicant meet the DVLA Group II medical conditions?** | | | | | **YES** |  | **NO** |  |
| **If not please indicate reasons why** | | | | | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **7.** | **ALCOHOL AND/OR DRUG MIS-USE**  **Please answer all questions in this section.**  **If your answer is YES to any question please give full details in Section 9.** | | | | |
| **i** | **Does the patient show any evidence of being addicted to the excessive use of alcohol?** | | | **Yes** | **No** |
| **ii** | **Does the patient show any evidence of being addicted to the excessive use of drugs?** | | | **Yes** | **No** |
| **In relation to section 7 does the applicant meet the DVLA Group II medical conditions?** | | **YES** |  | **NO** |  |
| **If not please indicate reasons why** | | | | | |
| **8.** | **EQUALITIES ACT 2010**  **Please answer all questions in this section.**  **If your answer is YES to any question please give full details in Section 9 and include copies of any relevant medical reports.** | | | | |
| **i** | **Does the patient have any medical or any physical condition that makes it impossible or unreasonably difficult for them to load or unload a passenger seated in a wheelchair into a vehicle, load a wheelchair into the boot of a vehicle or give reasonable assistance to a disabled passenger?** | | | **Yes** | **No** |
| **ii** | **Does the patient have any medical condition that requires an exemption from carrying guide dogs, hearing dogs or other assistance dogs?** | | | **Yes** | **No** |
| **9.** | **Additional Information** | | | | |
|  |  | | | | |

**General Practitioner**

# DECLARATION: Please read the following carefully before completing, signing and dating the declaration.

**If the applicant/patient is not a registered patient with your practice or you have not reviewed his/her medical records then do not complete the declaration.**

**I certify that I am familiar with the current requirements of Group 2 medical standards applied by the DVLA in the current version of “Medical Standards of Fitness to Drive”.**

**I certify** that I have reviewed the applicant’s medical records and that in my opinion nothing therein contradicts or tends to contradict the information given to me by the applicant.

**I certify** that I have today undertaken a medical examination of the applicant for the purpose of assessing their fitness to act as a driver of a Hackney Carriage or Private Hire driver under the DVLA Group 2 medical standards

# I certify that having regard to the foregoing, the applicant

**MEETS □**

**DOES NOT MEET □**

**the minimum standards required for the DVLA Group 2 medical standards.**

|  |  |
| --- | --- |
| **Doctor’s name:** | **Surgery Stamp:**  **(not accepted without surgery stamp)** |
| **Surgery name:** |
| **Surgery address:** |
| **Signed:** | **Date:** |