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

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

NOTE TO APPLICANT

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

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

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

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

To be completed by Applicant

Applicant's name

Address including postcode

Telephone Number

Email

Date of Birth

Version 1 – 01/11/2019

NOTE TO DOCTOR

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

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

All sections of this report must be completed in full.

To be completed by Doctor carrying out the examination

Practitioner Name

Surgery Stamp

Surgery Address

Surgery Telephone Number

Surgery Email

Medical examination report
Medical assessment
Must be filled in by a doctor

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

1 Neurological disorders

Please tick ✓ the appropriate box(es)

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

If **No**, go to section **2**

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

		Yes	No
1.	Has the applicant had any form of seizure?	☐	☐
	(a) Has the applicant had more than one attack?	☐	☐
	(b) Please give date of first and last attack		
	First attack 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**	☐	☐
	(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**	☐	☐
	(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 ultrasound been undertaken?	☐	☐
	If **Yes**, was the carotid artery stenosis >50% in either carotid artery?	☐	☐
3.	Sudden and disabling dizziness/vertigo within the last year with a liability to recur?	☐	☐
4.	Subarachnoid haemorrhage?	☐	☐
5.	Serious traumatic brain injury within the last 10 years?	☐	☐
6.	Any form of brain tumour?	☐	☐
7.	Other brain surgery or abnormality?	☐	☐
8.	Chronic neurological disorders?	☐	☐
9.	Parkinson's disease?	☐	☐
10.	Is there a history of blackout or impaired consciousness within the last 5 years?	☐	☐
11.	Does the applicant suffer from narcolepsy?	☐	☐

2 Diabetes mellitus

Does the applicant have diabetes mellitus? **Yes** ☐ **No** ☐

If **No**, go to section 3

If **Yes**, please answer **all** the questions below.

		Yes	No
1.	Is the diabetes managed by:		
	(a) Insulin? If **Yes**, please give date started on insulin 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**	☐	☐
	(c) Other injectable treatments?	☐	☐
	(d) A Sulphonylurea or a Glinide?	☐	☐
	(e) Oral hypoglycaemic agents and diet? If **Yes** to any of (a)-(e), please fill in current medication in **section 8**	☐	☐
	(f) Diet only?	☐	☐
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? If **Yes**, please give dates and details in **section 6**	☐	☐
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**	☐	☐
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

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3 Cardiac

a Coronary artery disease

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

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

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

1. Has the applicant suffered from angina? Yes ☐ No ☐
   If **Yes**, please give the date of the last known attack 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 (PCI)? Yes ☐ No ☐
   If **Yes**, please give date of most recent intervention D D M M Y Y
4. Coronary artery bypass 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 3c**

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

1. Has there been a **significant** disturbance of cardiac rhythm? i.e. sinoatrial disease, significant atrio-ventricular conduction defect, atrial flutter/fibrillation, narrow or broad complex tachycardia in the last 5 years? Yes ☐ No ☐
2. Has the arrhythmia been controlled satisfactorily for at least 3 months? Yes ☐ No ☐
3. Has an ICD or biventricular pacemaker (CRT-D type) been implanted? Yes ☐ No ☐
4. Has a pacemaker been implanted? Yes ☐ No ☐
   If **Yes:**
   (a) Please give date of implantation 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 3d**

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

1. Peripheral arterial disease (excluding Buerger's disease) Yes ☐ No ☐
2. Does the applicant have claudication? Yes ☐ No ☐
   If **Yes**, how long in minutes can the applicant walk at a brisk pace before being symptom-limited?
   Please give details
3. Aortic aneurysm? Yes ☐ No ☐
   If **Yes:**
   (a) Site of aneurysm: Thoracic ☐ Abdominal ☐
   (b) Has it been repaired successfully? ☐ ☐
   (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

d Valvular/congenital heart disease

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

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

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

1. Is there a history of congenital heart disease? Yes ☐ No ☐
2. Is there a history of heart valve disease? Yes ☐ No ☐
3. Is there a history of aortic stenosis? Yes ☐ No ☐
   If **Yes**, please provide relevant reports
4. Is there any history of embolism? (**not** pulmonary embolism) Yes ☐ No ☐
5. Does the applicant currently have significant symptoms? Yes ☐ No ☐
6. Has there been any progression since the last licence application? (if relevant) Yes ☐ No ☐

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

e Cardiac other

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

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

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

1. Established cardiomyopathy? Yes ☐ No ☐
2. Has a left ventricular assist device (LVAD) been implanted? Yes ☐ No ☐
3. A heart or heart/lung transplant? Yes ☐ No ☐
4. Untreated atrial myxoma? Yes ☐ No ☐

f Cardiac channelopathies

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

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

1. Brugada syndrome? Yes ☐ No ☐
2. Long QT syndrome? Yes ☐ No ☐

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

g Blood pressure

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

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

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

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

   ☐ 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 provide details in section 6 (including date of diagnosis and any treatment etc)

h Cardiac investigations

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

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

If **Yes,** please answer questions 1-6

1. Has a resting ECG been undertaken? Yes ☐ No ☐

   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 or comment at **section 6**

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

   If **Yes**, please give date D D M M Y Y and give details in **section 6**

   Please provide relevant reports if available

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

   (a) If **Yes**, please give date D D M M Y Y and give details in **section 6**

   (b) If undertaken, is/was the left ejection fraction greater than or equal to 40%? ☐ ☐

   Please provide relevant reports if available

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

   If **Yes**, please give date D D M M Y Y and give details in **section 6**

   Please provide relevant reports if available

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

   If **Yes**, please give date D D M M Y Y and give details in **section 6**

   Please provide relevant reports if available

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

   If **Yes**, please give date D D M M Y Y and give details in **section 6**

   Please provide relevant reports if available

4 Psychiatric illness

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

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

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

1. Significant psychiatric disorder within the past 6 months? Yes ☐ No ☐
2. Psychosis or hypomania/mania within the past 12 months, including psychotic depression? Yes ☐ No ☐
3. Dementia or cognitive impairment? Yes ☐ No ☐
4. Persistent alcohol misuse in the past 12 months? Yes ☐ No ☐
5. Alcohol dependence in the past 3 years? Yes ☐ No ☐
6. Persistent drug misuse in the past 12 months? Yes ☐ No ☐
7. Drug dependence in the past 3 years Yes ☐ No ☐

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

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 **Yes** ☐ **No** ☐

   (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	

10 Examining doctor's signature and stamp

To be completed by the doctor carrying out the examination.

Please ensure all sections of the form have been completed. The form will be returned to you if you don't do this.

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

Signature of practitioner

Date of signature D D M M Y Y

Doctor's stamp

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

To be completed by the Practitioner

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

I confirm that:-

	The applicant meets the Group 2 Medical Standard to drive as laid down by the DVLA
	The applicant does not meet the Group 2 Medical Standard to drive as laid down by the DVLA

Name of Practitioner

Signature of Practitioner

Date Signed

To be completed by the Applicant

Declaration

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

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

Signature of Applicant

Name of Applicant

Dated Signed

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

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

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