

Medical Report

Medical Report on an applicant for a licence to drive a Hackney Carriage or Private Hire Vehicle

You **MUST** send in this Medical Report form completed by your own GP, who has access to your current medical records.

A What you have to do

1. **BEFORE** consulting your Doctor please read the notes at **Section C, paragraphs 1, 2, 3 and 4. (Group 2 Medical Standards)**. If you have any of these conditions you may not be granted this entitlement.
2. If, after reading the notes, you have any doubts about your ability to meet the standards, consult your Doctor/Optician for advice **BEFORE** you arrange for this medical form to be completed. The Doctor will normally charge you for completing it. In the event of your application being refused, the fee you pay the Doctor is **NOT** refundable. Hastings Borough Council has **NO** responsibility for the fee payable to the Doctor.
3. Fill in **Section 8 AND Section 9** of this report in the presence of the Doctor carrying out the examination.
4. **If, in future, you develop symptoms of a condition which could affect safe driving and you hold any type of driving licence, you must inform the Drivers Medical Group, DVLA, Longview Road, Swansea SA99 1TU, and Hastings Borough Council.**
5. Please remove pages 1 and 2 before sending in the completed form with your application and check that all the sections have been completed fully. If you have any queries please telephone 01424 451042

B What the Doctor has to do

1. **Please arrange for the patient to be seen and a full examination to be undertaken.**
2. Please complete sections 1-7 and 10 of this report. You may find it helpful to consult the DVLA's "At a Glance" booklet.
3. Applicants who may be symptom free at the time of the examination should be advised that, if, in future they develop symptoms of a condition which could affect safe driving and they hold any type of driving licence (see Page 2 and 3 and "At A Glance" guide), they must inform the Drivers Medical Group, DVLA, Longview Road, Swansea, SA99 1TU and Hastings Borough Council.
4. **Please ensure that you have completed all the sections including consultant/specialist details where appropriate and your surgery/practice stamp.**
5. **Every effort should be made to establish medical history when completing this form. If this report does not bring out important clinical details with respect to driving, please give details in Section 7.**

C Group 2 Medical Standards

1. **EPILEPSY OR LIABILITY TO EPILEPTIC ATTACKS**
A diagnosis of epilepsy or spontaneous epileptic attack(s) requires 10 years free of further epileptic attack without taking anti-epilepsy medication during that 10-year period.
For conditions that cause an increased liability to epileptic attacks, the risk of attacks must fall to that of the general population.
2. **DIABETES**
Drivers with insulin treated diabetes may **NOT** obtain a licence.
3. **EYESIGHT**
All applicants, must be able to read in good light with glasses or corrective lenses if necessary, a number plate at 20.5 metres (67 feet) or 20 metres (65 feet), where narrower characters are displayed (50mm wide). The characters displayed on all new and replacement number plates manufactured from September 2001 are 50mm in width instead of 57mm.
In addition:
 - (i) **APPLICANTS MUST HAVE**
 - **A VISUAL ACUITY OF AT LEAST 6/9 IN THE BETTER EYE; AND**
 - **A VISUAL ACUITY OF AT LEAST 6/12 IN THE WORSE EYE; AND**
 - **IF THESE ARE ACHIEVED BY CORRECTION THE UNCORRECTED VISUAL ACUITY IN EACH EYE MUST BE NO LESS THAN 3/60.**

Applicant's name DOB

MEDICAL IN CONFIDENCE

4. OTHER MEDICAL CONDITIONS

In addition to those medical conditions covered by law, applicants (or licence holders) are likely to be refused if they are unable to meet the national recommended guidelines in the following situations:-

- Within 6 weeks of: myocardial infarction, any episode of unstable angina, CABG or coronary angioplasty
- Angina, heart failure or cardiac arrhythmia, which remain uncontrolled.
- Implanted cardiac defibrillator
- Hypertension where the blood pressure is persistently 180 systolic or more and/or 100 diastolic or more
- A stroke, or TIA within the last 12 months
- Unexplained loss of consciousness with liability to recurrence.
- Meniere's, or any other sudden and disabling vertigo within the past 1 year, and with a liability to recurrence.
- Insuperable difficulty in communicating by telephone in an emergency.
- Major brain surgery and/or recent severe head injury with serious continuing after effects.
- Parkinson's disease, multiple sclerosis or other chronic neurological disorders likely to affect safe driving.
- Psychotic illness, within the past 3 years.
- Serious psychiatric illness
- If major psychotropic or neuroleptic medication is being taken
- Alcohol and/or drug misuse within the past 1 year or alcohol and/or drug dependency in the past 3 years.
- Dementia
- Any malignant condition, within the last 2 years, with a significant liability to metastasise to the brain.
- Any other medical condition likely to affect the safe driving of a Hackney Carriage or Private Hire Vehicle

Applicant's name DOB

MEDICAL IN CONFIDENCE

Medical Examination Report

To be completed by the Doctor (please use black ink) Please answer all questions

Please give patient's weight (kg/st)

Height (cms/ft)

Please give details of smoking habits, if any

Please give number of alcohol units taken each week

Details of specialists(s)/consultants

Title/Name	Speciality	Hospital/clinic name

Date last seen

Current Medication

NAME OF DRUG	ILLNESS/REASON FOR USE	KNOWN SIDE EFFECTS

Date when first licensed to drive a Private Hire/Hackney Carriage

1 Vision (Please see Eyesight notes on page 2)

Please tick the appropriate box(es)

- | | YES | NO |
|--|--|----------------------------------|
| 1. Is the visual acuity AT LEAST 6/9 in the better eye, and AT LEAST 6/12 in the other?
(Corrective lenses may be worn) as measured with the full size 6m Snellen chart. | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do corrective lenses have to be worn to achieve this standard? | <input type="checkbox"/> | <input type="checkbox"/> |
| If YES , is the:- | <input type="checkbox"/> | <input type="checkbox"/> |
| (a) uncorrected acuity at least 3/60 in the right eye? | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) uncorrected acuity AT LEAST 3/60 in the left eye?
(3/60 being the ability to read the 6/60 line of the 6m Snellen chart at 3 metres) | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) correction well tolerated? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Please state the visual acuities of each eye in terms of the 6m Snellen chart: | | |
| UNCORRECTED | | CORRECTED (if applicable) |
| Right <input type="text"/> Left <input type="text"/> | Right <input type="text"/> Left <input type="text"/> | |
| 4. Is there a full binocular field of vision? (Central and or peripheral) | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Is there diplopia? (Controlled or uncontrolled) | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Does the applicant have any other ophthalmic condition?
If YES to 4,5 or 6, please give details in Section 7 and enclose relevant visual field charts or hospital letters. | <input type="checkbox"/> | <input type="checkbox"/> |

Applicant's name

DOB

MEDICAL IN CONFIDENCE

2 Nervous System

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Has the applicant ever had any form of epileptic attack? | <input type="checkbox"/> | <input type="checkbox"/> |
| (a) If YES , please give date of last attack | | |
| | <input type="text"/> | <input type="text"/> |
| (b) If treated, please give date when treatment ceased | | |
| | <input type="text"/> | <input type="text"/> |
| 2. Is there a history of blackouts or impaired consciousness within the last 5 years?
If YES , please give date(s) and details in SECTION 7 | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Does the applicant suffer from narcolepsy/cataplexy?
If YES , please give details in SECTION 7 | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Is there a history of, or evidence of any of the conditions listed at a-h below?
If NO , go to Section 3
If YES , please tick the relevant box(es) and give dates and full details as Section 7 | <input type="checkbox"/> | <input type="checkbox"/> |
| a) Stroke/TIA please delete as appropriate | <input type="checkbox"/> | |
| b) Sudden and disabling dizziness/vertigo within the last 1 year with a liability to recur | <input type="checkbox"/> | |
| c) Subarachnoid haemorrhage | <input type="checkbox"/> | |
| d) Serious head injury | <input type="checkbox"/> | |
| e) Brain tumour, either benign or malignant, primary or secondary | <input type="checkbox"/> | |
| f) Other brain surgery | <input type="checkbox"/> | |
| g) Chronic neurological disorders e.g. Parkinson's disease, Multiple Sclerosis | <input type="checkbox"/> | |
| h) Dementia or cognitive impairment | <input type="checkbox"/> | |

3 Diabetes Mellitus

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Does the applicant have diabetes mellitus?
If YES , please answer the following questions
If NO , proceed to SECTION 4 | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Is the diabetes managed by:-
(a) <i>Insulin?</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| If YES , date started on insulin | | |
| | <input type="text"/> | <input type="text"/> |
| (b) <i>Oral hypoglycaemic agents and diet?</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) <i>Diet only?</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Does the patient regularly test blood glucose? At least twice a day? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Is there evidence of:- | <input type="checkbox"/> | <input type="checkbox"/> |
| (a) Loss of visual field? | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Severe peripheral neuropathy, sufficient to impair limb function for safe driving? | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) Diminished/Absent awareness of hypoglycaemia? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Has there been laser treatment for retinopathy?
If YES, please give date(s) of treatment | <input type="checkbox"/> | <input type="checkbox"/> |
| | | <input type="text"/> |
| 6. Is there a history of hypoglycaemia during waking hours in the last
12 months requiring assistance from a third party? | <input type="checkbox"/> | <input type="checkbox"/> |
| If YES TO ANY OF 4-6 ABOVE, PLEASE GIVE DETAILS IN Section 7 | | |

Applicant's name DOB

MEDICAL IN CONFIDENCE

4 Psychiatric Illness

Is there a history of, or evidence of any of the conditions listed at 1-6 below?

YES NO

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

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

NB. If applicant remains under specialist clinic(s) ensure details are completed at Section 1.

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

5 Cardiac- Please follow the instructions in all Sections (5A-5G) giving details as required at Section 7.

5A Coronary Artery Disease

Is there a history of, or evidence of, coronary artery disease?

YES NO

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

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

1. Myocardial infarction?
If **YES**, please give date(s)
2. Coronary artery by-pass graft?
If **YES**, please give date(s)
3. Coronary Angioplasty (with or without stent)?
If **YES**, please give date(s)
4. Has the applicant suffered from Angina?
If **YES**, please give the date of the last attack

5B Cardiac Arrhythmia

Is there a history of, or evidence of cardiac arrhythmia?

YES NO

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

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

1. Has the applicant had a significant documented disturbance of cardiac rhythm within the past 5 years?
2. Has the arrhythmia been controlled satisfactorily for at least 3 months?
3. Has a cardiac defibrillator device been implanted?
4. Has a pacemaker been implanted?
If **YES**:-
 - a) Has the pacemaker been implanted for at least 6 weeks?
 - b) Since implantation, is the patient now symptom free from this condition?
 - c) Does the applicant attend a pacemaker clinic regularly?

Applicant's name DOB

MEDICAL IN CONFIDENCE

5C Peripheral Arterial Disease

Is there a history or evidence of, ANY of the following:

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>

If **YES** please tick ✓ ALL relevant boxes below, and give details at **Section 7** of the form.

PERIPHERAL ARTERIAL DISEASE

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

AORTIC ANEURYSM, IF YES: a) Site of aneurysm:

Thoracic

Abdominal

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>

b) Has it been repaired successfully?

c) Is the transverse diameter more than 5cms:

DIRECTION OF THE AORTA, IF YES:

a. Has it been repaired successfully:

5D Valvular/Congenital Heart Disease

Is there a history of, or evidence of valvular/ congenital heart disease?

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>

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

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

1. Is there a history of congenital heart disorder?
2. Is there a history of heart valve disease?
3. Is there any history of embolism? (**not** pulmonary embolism)
4. Does the applicant currently have significant symptoms?
5. Has there been any progression since the last licence application? (if relevant)

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

5E Cardiomyopathy

Please answer all the questions in this section

Does the applicant have a history of any of the following conditions:

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

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

(b) Established cardiomyopathy?

(c) A heart or heart/lung transplant?

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

5F Blood Pressure

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

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

If YES, please supply today's reading

Applicant's name

DOB

MEDICAL IN CONFIDENCE

5G Cardiac Investigations

This section must be completed for all applicants.

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Has a resting ECG been undertaken?
If YES , does it show;- | <input type="checkbox"/> | <input type="checkbox"/> |
| a) pathological Q waves? | <input type="checkbox"/> | <input type="checkbox"/> |
| b) left bundle branch block? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Has an exercise ECG been undertaken (or planned)?
If YES , please give date and give details in Section 7 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>Sight/copy of the exercise test result/report (if done in the last 3 years) would be useful</i> | | |
| 3. Has an echocardiogram been undertaken (or planned)?
If YES , please give date <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> and give details in Section 7 | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>Sight/copy of the echocardiogram result/report would be useful</i> | | |
| 4. Has a coronary angiogram been undertaken (or planned)?
If YES , please give date <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> and give details in Section 7 | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>Sight/copy of the angiogram result/report would be useful</i> | | |
| 5. Has a 24-hour ECG tape been undertaken (or planned)?
If YES , please give date <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> and give details in Section 7 | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>Sight/copy of the 24 hour tape result/report would be useful</i> | | |
| 6. Has a myocardial perfusion imaging scan been undertaken (or planned)?
If YES , please give date <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> and give details in Section 7 | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>Sight/copy of the scan result/report would be useful</i> | | |

6 General

Please answer all questions, in this section. If your answer is YES, please give full details in Section 7.

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Is there currently a disability of the spine or limbs, likely to impair control of the vehicle? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Is there a history of bronchogenic carcinoma or other malignant tumour, for example, malignant melanoma, with a significant liability to metastasise cerebrally?
If YES , please give dates and diagnosis and state whether there is current evidence of dissemination.. | <input type="checkbox"/> | <input type="checkbox"/> |
| | | |
| 3. Is the applicant profoundly deaf?
If YES ,
Is he/she able to communicate in the event of an emergency by speech or by using a device?
e.g. a MINICOM/text phone? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Is there a history of either renal or hepatic failure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Does the applicant have sleep apnoea system?
If YES , has it been controlled successfully? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Is there any other Medical Condition , causing excessive daytime sleepiness | <input type="checkbox"/> | <input type="checkbox"/> |
| 6a. If YES , please give details | | |

Applicant's name DOB

MEDICAL IN CONFIDENCE

please remember to complete SECTION 7 if you have answered YES to any question

SECTION 7

Please include any relevant test results, Forward Copies of all relevant hospital notes if available.

Applicant's name DOB

MEDICAL IN CONFIDENCE

8 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

On occasion, as part of the investigation into your fitness drive, Hastings Borough Council may require you to undergo a medical examination or some form of practical assessment. In these circumstances, those personnel involved will require your background medical details to undertake an appropriate and adequate assessment. Such personnel might include doctors, orthoptists at eye clinics or paramedical staff. Only information relevant to the assessment of your fitness to drive will be released. In addition, where the circumstances of your case appear exceptional, the relevant medical information would need to be considered by The Councils Medical Advisory.

Consent and Declaration

I authorise my Doctor(s) and Specialist(s) to release reports to Hastings Borough Council about my condition.

I authorise Hastings Borough to disclose such relevant medial information as may be necessary to the investigation of my fitness to drive, to Doctors, Paramedical Staff and Licensing Staff, and to release to my doctor(s) details of the outcome of my case and any relevant medical information.

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.

Signature

Date

9 Applicant Details

To be completed in the presence of the Medical Practitioner carrying out the examination

<i>Your Name</i>	<i>Date of Birth</i>	<input type="text"/>
<i>Your Address</i>	<i>Home telephone No.</i>	<input type="text"/>
<input type="text"/>	<i>Work/Daytime No.</i>	<input type="text"/>
<input type="text"/>	<i>Mobile telephone No.</i>	<input type="text"/>
<input type="text"/>	<i>Email Address</i>	<input type="text"/>

About your GP

Please give name, address & speciality of any consultant you are currently under

<i>GP</i>	<i>Consultant's Name</i>
<i>Address</i>	<i>Address</i>
<input type="text"/>	<input type="text"/>
<i>Telephone No.</i>	<i>Telephone No.</i>
<i>Email Address.</i>	<i>Email Address.</i>

Applicant's name DOB

10 Medical Practitioner Details

To be completed by Doctor carrying out the examination

Has this patient been registered with you for a period of at least 2 years?

YES NO

If the answer is NO, please give details of previous registered Medical Practitioner.

<i>Name</i>
<i>Address</i>

I Certify that in my opinion the applicant is FIT/UNFIT (please delete as necessary) to drive a Hackney Carriage or Private Hire Vehicle

Surgery Stamp

<i>Name</i>
<i>Address</i>

--

Signature of Medical Practitioner

Date

G P Number

Applicant's name DOB