MEDICAL IN CONFIDENCE

Telephone: 01424 451042
Website: www.hastings.gov.uk
Email: licensing@hastings.gov.uk
Muriel Matters House, Breeds Place, Hastings, TN34 3UY

MEDICAL REPORT

Please write clearly in **block capitals** and in **black ink.**

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 will only be able to obtain/continue holding a licence if specific conditions are complied with. Advice should be sought from medical adviser.

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 _____

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 EXAMINATION REPORT

To be completed by the **Doctor**. Please answer all questions
Please write clearly in **block capitals** and in **black ink**

Please give patients 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 specialist(s)/consultants & Date last seen

TITLE/NAME	SPECIALITY	HOSPITAL/CLINIC NAME
Date: D D M M Y Y Y Y	Date: D D M M Y Y Y Y	Date: D D M M Y Y Y Y

Current Medication

NAME OF DRUG	ILLNESS/REASON FOR USE	KNOWN SIDE EFFECTS

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

1. Vision (Please see Eyesight notes on page 2)

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.	☐ Yes ☐ No
2.	Do corrective lenses have to be worn to achieve this standard?	☐ Yes ☐ No
	If YES, is the:	
	(a) Uncorrected acuity at least 3/60 in the left eye?	☐ Yes ☐ No
	(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)	☐ Yes ☐ No
	(c) correction well tolerated?	☐ Yes ☐ No

3. Please state the visual acuities **of each eye** in terms of the 6m Snellen chart:

UNCORRECTED				**CORRECTED** ***(if applicable)***			
Right		Left		Right		Left	

4.	Is there a full binocular field of vision? (Central and or Peripheral)	☐ Yes ☐ No
5.	Is there diplopia (Controlled or uncontrolled)	☐ Yes ☐ No
6.	Does the applicant have any other ophthalmic condition?	☐ Yes ☐ No

If **YES** to 4,5 or 6, please give details in **Section 7** and enclose relevant visual field charts or hospital letters.

Applicant's name _____ DOB _____

2. Nervous System

1.	Has the applicant ever had any form of epileptic attack?	☐ Yes ☐ No
	(a) If YES, please give date of last attack	D D M M Y Y Y Y
	(b) If treated, please give date when treatment ceased	D D M M Y Y Y Y
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***	☐ Yes ☐ No
3.	Does the applicant suffer from narcolepsy/cataplexy? *If **YES**, please give details in **SECTION 7***	☐ Yes ☐ No
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**	☐ Yes ☐ No

a) Stroke/TIA *please delete as appropriate*	☐
b) Sudden and disabling dizziness/vertigo within the last 1 year with a liability to recur	☐
c) Subarachnoid haemorrhage	☐
d) Serious head injury	☐
e) Brain tumour, either benign or malignant, primary or secondary	☐
f) Other brain surgery	☐
g) Chronic neurological disorders e.g. Parkinson's disease, Multiple Sclerosis	☐
h) Dementia or cognitive impairment	☐

3. Diabetes Mellitus

1.	Does the applicant have diabetes mellitus? *If **YES**, please answer the following questions* *If **NO**, proceed to **Section 4***	☐ Yes ☐ No
2.	Is the diabetes managed by:- (a) Insulin?	☐ Yes ☐ No
	If **YES**, date started on insulin	D D M M Y Y Y Y
	(b) Oral hypoglycaemic agents and diet?	☐ Yes ☐ No
	(c) Diet only?	☐ Yes ☐ No
3.	Does the patient regularly test blood glucose? At least twice a day?	☐ Yes ☐ No
4.	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 or hypoglycaemia?	☐ Yes ☐ No
5.	Has there been laser treatment for retinopathy?	☐ Yes ☐ No
	If **YES**, please give date(s) of treatment:	
6.	Is there a history of hypoglycaemia during waking hours in the last 12 months requiring assistance from a third party?	☐ Yes ☐ No

If **YES** TO ANY OF 4-6 ABOVE, PLEASE GIVE DETAILS IN **Section 7**

Applicant's name _____ DOB _____

4. Psychiatric Illness

Is there a history of, or evidence of any of the conditions listed at 1-6 below? 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	☐ Yes ☐ No
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? If **NO**, proceed to **Section 5B** If **YES** please answer all questions below and give details at **Section 7** of the form	☐ Yes ☐ No
1. Myocardial infarction? *If **YES**, please give date(s)*	☐ Yes ☐ No D D M M Y Y Y Y
2. Coronary artery by-pass graft? *If **YES**, please give date(s)*	☐ Yes ☐ No D D M M Y Y Y Y
3. Coronary Angioplasty (with or without stent)? *If **YES**, please give date(s)*	☐ Yes ☐ No D D M M Y Y Y Y
4. Has the applicant suffered from Angina? *If **YES**, please give the date of the last attack*	☐ Yes ☐ No D D M M Y Y Y Y

5B Cardiac Arrhythmia

1. Has the applicant had a significant documented disturbance of cardiac rhythm within the past 5 years?	☐ Yes ☐ No
2. Has the arrhythmia been controlled satisfactorily for at least 3 months?	☐ Yes ☐ No
3. Has a cardiac defibrillator device been implanted?	☐ Yes ☐ No
4. Has a pacemaker been implanted?	☐ Yes ☐ No
If **YES**, a) Has the pacemaker been implanted for at least 6 weeks?	☐ Yes ☐ No
b) Since implantation, is the patient now symptom free from this condition?	☐ Yes ☐ No
c) Does the applicant attend a pacemaker clinic regularly?	☐ Yes ☐ No

Applicant's name _____ DOB _____

5C Peripheral Arterial Disease		
Is there a history or evidence of ANY of the following: If **YES** please **tick** √ ALL relevant boxes below, and give details at **Section 7** of the form		
PERIPHERAL ARTERIAL DISEASE	☐ Yes	☐ No
AORTIC ANEURYSM	☐ Yes	☐ No
If YES, a) Site of aneurysm	☐ Thoracic	☐ Abdominal
b) Has it been repaired successfully?	☐ Yes	☐ No
c) Is the transverse diameter more that 5cms?	☐ Yes	☐ No
DIRECTION OF THE AORTA, IF YES		
a) Has it been repaired successfully?	☐ Yes	☐ No
5D Valvular/Congenital Heart Disease		
Is there a history of, or evidence of valvular/ congenital heart disease? If **NO**, proceed to **Section 5E** If **YES** please answer all questions below and give details at **Section 7** of the form	☐ Yes	☐ No
1. Is there a history of congenital heart disorder?	☐ Yes	☐ No
2. Is there a history of heart valve disease?	☐ Yes	☐ No
3. Is there any history of embolism? (**not** pulmonary embolism)	☐ Yes	☐ No
4. Does the applicant currently have significant symptoms?	☐ Yes	☐ No
5. Has there been any progression since the last licence application? (if relevant)	☐ Yes	☐ No
5E Cardiomyopathy		
Please answer all the questions in this section **Does the applicant have a history of any of the following conditions:**		
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
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 180cm HG or greater	☐ Yes	☐ No
2. Is today's diastolic pressure 100mm HG or greater	☐ Yes	☐ No
3. Is the applicant on anti-hypertensive treatment?	☐ Yes	☐ No
If **YES**, please supply today's reading:		

Applicant's name _____ DOB _____

5G Cardiac Investigations		
This section must be completed for all applicants		
1. Has a resting ECG been undertaken?	☐ Yes	☐ No
If YES, does it show: a) pathological Q waves?	☐ Yes	☐ No
b) left bundle branch block?	☐ Yes	☐ No
2. Has an exercise ECG been undertaken (or planned)? If **YES,** please give date and give details in **Section 7** *Sight/copy of the exercise test result/report (if done in the last 3 years) would be useful*	☐ Yes D D M M Y Y Y Y	☐ No
3. Has an echocardiogram been undertaken (or planned)? If **YES,** please give date and give details in **Section 7** *Sight/copy of the echocardiogram result/report would be useful*	☐ Yes D D M M Y Y Y Y	☐ No
4. Has a coronary angiogram been undertaken (or planned)? If **YES,** please give date and give details in **Section 7** *Sight/copy of the angiogram result/report would be useful*	☐ Yes D D M M Y Y Y Y	☐ No
5. Has a 24-hour ECG tape been undertaken (or planned)? If **YES,** please give date and give details in **Section 7** *Sight/copy of the 24 hour tape result/report would be useful*	☐ Yes D D M M Y Y Y Y	☐ No
6. Has a myocardial perfusion imaging scan been undertaken (or planned)? If **YES,** please give date and give details in **Section 7** *Sight/copy of the scan result/report would be useful*	☐ Yes D D M M Y Y Y Y	☐ No

6 General		
1. Is there **currently** a disability of the spine or limbs, likely to impair control of the vehicle?	☐ Yes	☐ No
2. 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:		
3. Is the applicant profoundly deaf?	☐ Yes	☐ No
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	☐ Yes	☐ No
4. Is there a history of either renal or hepatic failure?	☐ Yes	☐ No
5. Does the applicant have sleep apnoea syndrome?	☐ Yes	☐ No
If **YES**, has it been controlled successfully?	☐ Yes	☐ No
6. Is there any other **Medical Condition**, causing excessive daytime sleepiness?	☐ Yes	☐ No
If **YES**, please give details		

Applicant's name _____ DOB _____

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 _____

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 to 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 Council 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.

Signed:		Date:	D	D	M	M	Y	Y	Y	Y
Print Name:									

9 Applicants Details

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

Your Name		Date of Birth:	D	D	M	M	Y	Y	Y	Y
Your Address		Home Telephone No:							
		Work/Daytime No:							
		Mobile Telephone No:							
		Email Address:							

About your GP	
GP	
Address	
Telephone No:	
Email:	

Please give name, address & speciality of any consultant you are currently under	
Consultants Name	
Address	
Telephone No:	
Email:	

Applicant's name _____ DOB _____

10 Medical Practitioner Details		
To be completed by Doctor carrying out the examination		
Has the patient been registered with you for a period of 2 years?	☐ Yes	☐ No
If the answer is NO, please give details of previous registered Medical Practitioner		
Name:		
Address:		
Postcode		

I have today examined the applicant for the purposes of establishing medical fitness to the DVLA Group 2 Entitlement. In making this decision I have consulted the DVLA "At a Glance Guide to the current Medical Standards of Fitness to Drive", in addition I have had sight of the applicants medical records and considered their content prior to reaching my decision. I now consider the applicant:			
Please tick relevant box:			
Is **fit to drive** a licensed vehicle:	☐	Is **not fit to drive** a licensed vehicle	☐

Surgery Stamp

Name		
Address		

Signature of Medical Practitioner		Date	D	D	M	M	Y	Y	Y	Y
GP Number										

Applicant's name ____ DOB ____