MEDICAL EXAMINATION FORM
For applicants for a Hackney Carriage or Private Hire Vehicle Driver's Licence

Notes for the applicant

THIS MEDICAL REPORT MUST BE COMPLETED BY A DOCTOR IN YOUR REGISTERED GROUP PRACTICE

If you knowingly give false information in this examination you are liable to prosecution.

Before you can be issued with a licence to drive a hackney carriage or private hire vehicle the Council must be satisfied that you are fit for this type of driving. For this reason, your registered Doctor must fill in **Part B** of this Medical Report.

Completed forms should be sent to:

Licensing Department, South Walks House, South Walks Road, Dorchester DT1 1UZ

Your doctor will **not** be able to give you this report free under the National Health - you may have to pay a fee. If you have any doubts about your fitness, consult your Doctor **before** you take this form to him for an examination.

Please fill in **Part A** of this form, make sure you answer all the questions. Please write in CAPITALS
Do not sign the authorisation at Section 11 until you are with the Doctor who is going to fill in Part B of the report

Part A

To be filled in by the applicant
Please answer all questions and write in CAPITALS

If you have held a hackney carriage/private hire vehicle drivers licence before, when was your first licence issued and which authority issued it.	Date of first licence:
	Issuing authority:

If you have held a PCV/LGV drivers licence issued by the DVLA when did you last pass the medical required for that licence	Date of DVLA Medical (if appropriate):

Full name:	
Address:	
Postcode:	

Date of Birth:	
Home telephone number:	
Work telephone number:	

Give the name and address of the doctor (or group practice) that you have been registered with for the last 12 months

Name:	
Address:	
Postcode:	

Updated September 2015

Notes for the Doctor

Please read these notes before undertaking the examination.

Please complete Part B of this report, having regard to the 'Notes for Guidance' published by the British Medical Association for Doctors conducting these examinations and where necessary, to the booklet 'Medical Aspects of Fitness to Drive' published by the Medical Commission for Accident Prevention, and the DVLA's 'At a Glance Guide'.

If you have any doubt about the applicant's fitness for this type of driving, please contact
The Licensing Department by calling 01305 838028 or write to;
Licensing Department, South Walks House, South Walks Road, Dorchester DT1 1UZ

Please tick the answer that applies and complete all answers.

The purpose of the report is to determine the applicant's fitness to drive hackney carriages/private hire vehicles. The council may need to make further enquiries if there is any doubt as to the applicant's fitness.

The medical standards for hackney carriage/private hire vehicle driver licences are higher than they are for ordinary driving entitlement. These standards are briefly explained below.

By Law a licence may not be issued if the applicant:-

• has had an epileptic fit attack during the last 10 year period and/or has taken anti-epileptic medication during that same period; or
• if corrective eye lenses are used, the corrective power is greater than plus 8 (+8) dioptres; or
• if there is complete loss of vision in one eye or corrected acuity of less than 3/60 (Snellen decimal 0.05) in one eye, applicants are barred in law from holding a Group 2 licence.(It is necessary for all drivers of Group 2 vehicles to be able to meet the prescribed and relevant Group 1 visual acuity requirements. Grandfather rights exist if Group 2 licence has been issued prior to 01.01.1991 in knowledge of monocularity); or
• is an insulin dependent diabetic, unless he/she held a valid licence on 1.4.91 and the Traffic Commissioner who issued that licence had knowledge of the condition before 1.1.91. or the C1/C1E exemption criteria are met.

In addition the licence may be refused if the applicant:-

• has had a myocardial infarction, CABG or coronary angioplasty
• suffers persistent arrhythmia
• has uncontrolled established hypertension
• has had a stroke, TIA, or unexplained loss of consciousness
• has had severe head injury with continuing after-effects, or major brain surgery
• has Parkinson's disease, multiple sclerosis or Meniere's disease
• is being treated for or has suffered a psychotic illness in the past 5 years
• has had alcohol or drug addiction problems in the past 5 years
• has serious difficulty communicating by telephone
• has diplopia or visual field defect
• has any other condition which would cause problems for hackney carriage/private hire vehicle driving unless the applicant can prove that he/she is otherwise medically fit to obtain a licence.

Important- Any essential, additional information should be given in a separate letter and attached.

Part B

Vision assessment

To be filled in by a doctor or optician/optometrist

If correction is needed to meet the eyesight standard for driving, ALL questions must be answered. If correction is NOT needed, questions 4 & 5 can be ignored.

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.

Snellen readings with a plus (+) or minus (-) are not acceptable. If 6/75 , 6/60 standard is not met, the applicant may need further assessment by an optician.

	R	L
Uncorrected		
Corrected (using the prescription worn for driving)		

	YES	NO
3 Is the visual acuity at least 6/7.5 in the better eye and at least 6/60 in the other eye (corrective lenses may be worn to meet this standard)	☐	☐
4 Were corrective lenses worn to meet this standard?	☐	☐
If **YES -** glasses / contact lenses / both together		
5 If glasses (not contact lenses) are worn for driving, is the corrective power greater than plus 8 (+8) dioptres in any meridian of either lens?	☐	☐
6 If a correction is worn for driving, is it well tolerated?	☐	☐
If NO, please give full details in the box provided		
7 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 is considered necessary, council will commission this at a later date		
8 Is there diplopia?	☐	☐
If **YES,** is it controlled?	☐	☐
If **Yes**, please give full details in the box provided		
9 Does the applicant on questioning, report symptoms ofo intolerance to glare and/or impaired contrast sensitivity and/or impaired twilight vision that impairs their ability to drive?	☐	☐
10 Does the applicant have any other ophthalmic condition?	☐	☐
If **YES, please give full details in the box provided**		

Details / additional information

Date of examination:

DD / MM / YY

Name of examining doctor/optician (print) :

Signature:

Doctor/optometrist/optician's stamp

1. Nervous system

Please tick ✓ the appropriate box(es)

		YES	NO
1	Has the applicant had any form of seizure?	☐	☐
	If **YES**, please answer questions a-f		
a)	Has the applicant had more than one attack?	☐	☐
b)	Please give date of first and last attack First attack DD / MM / YY		
	Last attack DD / MM / YY		
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 DD / MM / YY		
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 the above, please supply reports if available		
2	Is there a history of blackout or impaired conciousness within the last 5 years?	☐	☐
3	Does the applicant suffer from narcolepsy or cataplexy?	☐	☐
	If **YES**, please give date(s) and details in **section 6**		
4	Is there a history of, or evidence of **ANY** conditions listed at a-h?	☐	☐
	If **NO,** go to **section 2**		
	If **YES**, please give full details at **section 6** and supply relevant reports		
a)	Stroke or TIA	☐	☐
	If **YES**, please give date DD / MM / YY		
	Has there been a full recovery?	☐	☐
	Has a carotid ultra sound been undertaken?	☐	☐
b)	Sudden and disabling dizziness/vertigo within the last year with a liability to recur	☐	☐
c)	Subarachnoid haemorrhage	☐	☐
d)	Serious traumatic brain injury within the last 10 yrs	☐	☐
e)	Any form of brain tumour	☐	☐
f)	Other brain surgery or abnormality	☐	☐
g)	Chronic neurological disorders	☐	☐
h)	Parkinson's disease	☐	☐

2. Diabetes Mellitus

		YES	NO
1	Does the applicant have diabetes mellitus?	☐	☐
	If **NO**, please go to section 3		
	If **YES**, please answer the following questions.		
2	Is the diabetes managed by:-		
a)	Insulin?	☐	☐
	If **YES**, please give date started on insulin DD / MM / YY		
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 Glinide?	☐	☐
e)	Oral hypoglycaemic agents and diet?	☐	☐
f)	Diet only?	☐	☐
	If **YES** to any of a-e, please fill in current medication in **section 8**		
3 a)	Does the applicant test blood glucose at least twice every day?	☐	☐
b)	Does the applicant test at times relevant to driving? **(no more than 2 hours before the start of the first journey and every 2 hours whilst 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	☐	☐
4	Is there any evidence of impaired awareness of hypoglycaemia?	☐	☐
5	Is there a history of hypoglycaemia in the last 12 months requiring the assistance of another person?	☐	☐
6	Is there evidence of :-		
a)	Loss of visual field?	☐	☐
b)	Severe peripheral neuropathy, sufficient to impair limb function for safe driving?	☐	☐
	If **YES** to any of 5-6 above, please give details in **section 6**		
7	Has there been laser treatment or intra-vitreal treatment for retinopathy?	☐	☐
	If YES, please give details of treatment		

3. Psychiatric illness YES NO

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

Please enclose relevant hospital notes

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

1 Significant psychiatric disorder within the past 6 months

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

3 Dementia or cognitivie impairment

3 Dementia or cognitive impairment

4 Persistent alcohol misuse in the past 12 months

5 Alcohol dependence in the past 3 years

6 Persistent drug misuse in the past 12 months

7 Drug dependence in the past 3 years

If yes to ANY of the questions 4-7, please state how long this has been controlled

Please give details of past consumption or name of drug(s) and frequency

4. Cardiac YES NO

4A Coronary artery disease

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

If **NO**, go to section **4B**

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

1 Has the applicant suffered from Angina?
If **YES**, please give the date of the last known attack

DD / MM / YY

2 Acute coronary syndromes including Myocardial infarction?
If **YES**, please give date

DD / MM / YY

3 Coronary angioplasty (P.C.I.)
If **YES**, please give date of most recent intervention

DD / MM / YY

4 Coronary artery by-pass graft surgery?
If **YES**, please give date?

DD / MM / YY

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?

4B Cardiac arrhythmia YES NO

Is there a history of, or evidence of, cardiac arrhythmia?
If **NO**, go to **section 4C**
If **YES**, please answer all questions below and give details in **section 6**

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

2 Has the arrhythmia been controlled satisfactorily for at least 3 months?

3 Has an ICD or biventricular pacemaker (CRT-D type) been implanted?

4 Has a pacemaker been implanted?
If **YES**:-

a) Please give date of implanation

DD / MM / YY

b) Is the applicant free of symptoms that caused the device to be fitted?

c) Does the applicant attend a pacemaker clinic regularly?

4C Peripheral arterial disease (excluding Buerger's disease) aortic aneurysm/ dissection YES NO

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

If **NO**, go to **section 4D**
If **YES**, please answer all questions below and give details in **section 6**

1 Peripheral arterial disease (excluding Buerger's disease)

2 Does the applicant have claudication?

If **YES**, how long in minutes can the applicant walk at a brisk pace before being symptom-limited?

3 Aortic aneurysm
If **YES**:

a) Site of Aneurysm: Thoracic / Abdominal

b) Has it been repaired successfully?

c) Is the transverse diameter currently >5.5cm

If **NO,** please provide latest measurement and date obtained

DD / MM / YY

4 Dissection of the aorta repaired successfully
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?
If **YES**, provide relevant hospital notes

4D Valvular/congenital heart disease

Is there a history of, or evidence of, valvular/congenital heart disease? YES ☐ NO ☐

If **NO,** go to **section 4E**

If **YES**, please answer all questions below and give details in **section 6** of the form

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 a history of embolism? (**NOT** pulmonary embolism) YES ☐ NO ☐

5 Does the applicant currently have significant symptoms? YES ☐ NO ☐

6 Has there been any progession since the last licence application? (if relevant) YES ☐ NO ☐

4E Cardiac other

Does the applicant have a history of **ANY** of the following conditions: YES ☐ NO ☐

If **NO**, go to **section 4F**

If **YES**, please answer **ALL** questions and give details in **section 6**

a) a history of, evidence of, heart failure? YES ☐ NO ☐

b) established cardiomyopathy? YES ☐ NO ☐

c) has a Left Ventricular Assist Device (LVAD) been implanted? YES ☐ NO ☐

d) a heart or heart/lung transplant? YES ☐ NO ☐

e) untreated atrial myxoma YES ☐ NO ☐

4F Cardiac investigations

This section must be filled in 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 ☐

c) right bundle branch block? YES ☐ NO ☐

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 and enter details in **section 6**

DD / MM / YY

Please provide relevant reports if available

3 Has an echocardiogram been undertaken (or planned)? YES ☐ NO ☐

a) If **YES**, please give date and enter details in **section 6**

DD / MM / YY

b) If undertaken, is/was the left ejection fraction greater than or equal to 40%? YES ☐ NO ☐

Please provide relevant reports if available

4 Has a coronary angiogram been undertaken (or planned) ? YES ☐ NO ☐

If **YES,** please give date and enter details in **section 6**

DD / MM / YY

Please provide relevant reports if available

5 Has a 24 hour ECG tape been undertaken (or planned) ? YES ☐ NO ☐

If **YES,** please give date and enter details in **section 6**

DD / MM / YY

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 and enter details in **section 6**

DD / MM / YY

Please provide relevant reports if available

4G Cardiac channelopathies

Is there a history of, or evidence of either of the following conditions? YES ☐ NO ☐

If **NO**, go to **section 4H**

1 Brugada syndrome? YES ☐ NO ☐

2 Long QT syndrome? YES ☐ NO ☐

If **YES** to either, please give details in section 6

4H Blood pressure

1 Please record today's blood pressure reading

2 Is the applicant on anti-hypertensive treatment? YES ☐ NO ☐

If **YES**, provide three previous readings with dates if available

DD / MM / YY

DD / MM / YY

DD / MM / YY

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

5.General

Please answer **ALL** questions. If **YES** to any give full details in **section 6**.

	YES	NO
1 Is there currently any functional impairment that is likely to affect control of the vehicle?	☐	☐
2 Is there a history of bronchogenic carcinoma or other malignant tumour with a significant liability to metastasise cerebrally?	☐	☐
3 Is there any illness that may cause significant fatigue or cachexia that affects safe driving?	☐	☐
4 Is the applicant profoundly deaf?	☐	☐
If **YES**, is the applicant able to communicate in the event of an emergency by speech or by using a device, e.g. a textphone?	☐	☐
5 Does the applicant have a history of liver disease of any origin?	☐	☐
If **YES**, please give details in **section 6**		
6 Is there a history of renal failure?	☐	☐
If **YES**, please give details in **section 6**		
7 a) Is there a history of, or evidence of, obstructive sleep apnoea syndrome?	☐	☐
b) Is there any other **medical condition** causing excessive daytime sleepiness?	☐	☐

If **YES**, please give diagnosis

a) If Obstructive Sleep Apnoea Syndrome, please indicate the severity

- Mild (AHI <15) ☐
- Moderate (AHI 15 - 29) ☐
- Severe (HI >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. Please give details in section 6

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

i) Date of diagnosis

DD / MM / YY

	YES	NO
ii) Is it controlled successfully?	☐	☐

iii) If **YES**, please state treatment

iv) Is applicant compliant with treatment?	☐	☐

iv) Please state period of control

v) Date of last review

DD / MM / YY

8 Does the applicant have severe symptomatic respiratory disease causing chronic hypoxia?	☐	☐
9 Does any medication currently taken cause the applicant side effects that could affect	☐	☐

If **YES**, please provide details of medication and symptoms in **section 6**

	YES	NO
10 Does the applicant have an ophthalmic condition?	☐	☐

If **YES**, please provide details in **section 6**

11 Does the applicant have any other medical condition that could affect safe driving?	☐	☐

If **YES**, please provide details in **section 6**

6. Further details

Please forward copies of relevant hospital notes. **PLEASE DO NOT** send any notes note related to fitness to drive.

7. Consultants' details

Details of type of specialist(s)/consultants, including address

Consultant in:
Name:
Address:

Date of last appointment: DD/MM/YY

Consultant in:
Name:
Address:

Date of last appointment: DD/MM/YY

Consultant in:
Name:
Address:

Date of last appointment: DD/MM/YY

8. Medication

Please provide details of all current medication (continue on 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. Doctor's details (please print name and address in capital letters

To be filled in by doctor carrying out the examination

Please ensure all sections of the form have been completed. Failure to do so will result in the form being rejected.

Name:
Address:
Telephone no:
Email address:
Fax no:

Surgery stamp

I consider that this person MEETS the Group 2 standards

Signature of the Registered Medical Practitioner

I consider that this person DOES NOT MEET the Group 2 standards

Signature of the Registered Medical Practitioner

Date of examination

DD / MM / YY

11. Access to Medical Records Act & Authority for the Release of Medical Information

To be completed by the applicant whilst in the presence of the Dr completing the medical - Please use CAPITALS

Applicants details:

Full name:
Address:
Email address:
Telephone number:
Date of birth:
APPLICATION FOR HACKNEY CARRIAGE/PRIVATE HIRE DRIVERS

About your doctor/group practice

Name of Medical Practitioner:
Address:
Telephone number:

Consent and declaration

I hereby consent to a medical report being supplied, in confidence, to the appointed Medical Advisor. I have read the summary of my rights below and other relevant provisions under the Access Medical Reports 1988.

(*delete as appropriate) *I do/I do not wish to have access to the medical report before it is supplied.

Signed:
Date:

ACCESS TO MEDICAL REPORTS ACT 1988

This is a summary of your principal rights under the Act, which is concerned with reports provided for employment or insurance purposes by a medical practitioner who is, or has been responsible for your clinical care.

Option A
You may withhold your consent to an application for the report from a medical practitioner.

Option B
You may consent to the application, but indicate your wish to see the report before it is supplied. (You must make the necessary arrangements with the medical practitioner to see the report; it will not be sent to you automatically)

The medical practitioner will be informed that you wish to have access to the report and will allow 21 days for you to see and approve it before it is supplied to the applicant. If the medical practitioner has not heard from you in writing within 21 days of the application for the report being made he/she will assume that you do not wish to see the report and that you consent to its being supplied.

When you see the report, if there is anything in it which you consider incorrect or misleading you can request (but this request must be in writing) that the medical practitioner amend the report but he/she is not obliged to do so. If the medical practitioner refuses to amend it you may

i) withdraw consent for the report to be issued
ii) ask the medical practitioner to attach to the report a statement setting out your own views
iii) agree to the report being issued unchanged

OPTION C
You may consent to the application for the report but indicate that you do not wish to see the report before it is supplied. Should you change your mind after the application is made and notify the medical practitioner in writing he/she should allow 21 days to elapse after such notification so that you may arrange to have access to the report (if the report has not already been supplied before you change your mind)

OPTION D
Whether or not you decide to seek access to the report before it is supplied, you have the right to seek access to it from the medical practitioner at any time up to six months after it was supplied.

Please note that where a copy of the medical report is supplied to you the practitioner may charge a reasonable fee to cover the cost of supplying it.