

REPORT OF MEDICAL EXAMINATION OF APPLICANT FOR HACKNEY CARRIAGE OR PRIVATE HIRE DRIVERS LICENCE

Local Government (Miscellaneous Provisions) Act 1976 Town Police Clauses Act 1847

APPLICANT DETAILS (to be completed by applicant)					
1	Forename				
2	Surname				
3	Address				
4	Date of birth				
DECLARATION AND SIGNATURE (to be completed by applicant)					
	I hereby declare that I give consent to the medical examination being carried out.				
	I hereby declare that the information contained within the questionnaire is true to the best of my knowledge.				
	I hereby authorise the doctor to release reports and information about my medical fitness to the council.				
5	Applicant's signature				
6	Date of signature				
	DECLARATION AND SIGNATURE (to be completed by the doctor)				
	I hereby declare that I am a registered doctor with access to the applicant's medical records. I hereby declare that I have considered the applicant's medical history. I hereby declare that I have identified the applicant prior to carrying out the assessment. I understand that the applicant is to be assessed in accordance with the DVLA's Group 2 Medical Standards (applicable to drivers of lorries and buses).				
l he	reby declare that, in my opinion, the applicant:				
Has	satisfied OR Has not satisfied				
the	criteria laid down in the DVLA's Group 2 Medical Standards.				
7	Doctor's name				
8	Doctor's signature				
9	Date of signature				

Medical examination report

Vision assessment

To be filled in by an optician, optometrist or doctor

 Please confirm () the scale you are using to express the applicant's visual acuities. Snellen Snellen expressed as a decimal LogMAR 	5. Does the applicant report symptoms of any of the following that impairs their ability to drive? Please indicate below and give full details
2. The visual acuity standard for Group 2 driving is at least 6/7.5 in one eye and at least 6/60 in the other.(a) Please provide uncorrected visual acuities for each eye. Snellen readings with a plus (+) or minus (-) are not acceptable. If 6/7.5, 6/60	in Q7 below. (a) Intolerance to glare (causing incapacity rather than discomfort) and/or (b) Impaired contrast sensitivity and/or (c) Impaired twilight vision
standard is not met, the applicant may need further assessment by an optician. R L Yes No (b) Are corrective lenses worn for driving?	6. Does the applicant have any other ophthalmic condition affecting their visual acuity or visual field? If Yes, please give full details in Q7 below.
If No, go to Q3. If Yes, please provide the visual acuities using the correction worn for driving. Snellen readings with a plus (+) or minus (-) are not acceptable. If 6/7.5, 6/60 standard is not met, the applicant may need further assessment by an optician.	7. Details or additional information
Co) What kind of corrective lenses are worn to meet this standard? Glasses Contact lenses Both together	
(d) If glasses are worn for driving, is the corrective power greater than plus (+)8 dioptres in any meridian of either lens? (e) If correction is worn for driving, is it well tolerated? If No, please give full details in Q7.	Name of examining doctor or optician undertaking vision assessment I confirm that this report was filled in by me at
3. Is there a history of any medical condition that may affect the applicant's binocular field of vision (central and/or peripheral)? If Yes, please give full details below.	examination and the applicant's history has been taken into consideration. Signature of examining doctor or optician
	Date of signature Please provide your GOC or GMC number
4. Is there diplopia? (a) Is it controlled? Please indicate below and give full details in Q7. Patch or Glasses Other glasses with with/without frosted glass prism provide details)	Doctor, optometrist or optician's stamp
Applicant's full name	Date of birth DDMMYY detach this page

Medical examination report

Medical assessment

Must be filled in by a doctor

1 Neurological disorders	2 Diabetes mellitus
Please tick \(\strict \) the appropriate boxes Is there a history or evidence of any neurological disorder (see conditions in questions 1 to 11 below)? If No, go to section 2, Diabetes mellitus If Yes, please answer all questions below and enclose relevant hospital notes.	Yes No Does the applicant have diabetes mellitus? If No, go to section 3, Cardiac If Yes, please answer all questions below. 1. Is the diabetes managed by: (a) Insulin? Yes No Yes No
1. Has the applicant had any form of seizure? (a) Has the applicant had more than one seizure episode? (b) If Yes, please give date of first and last episode. First episode Last episode Last episode (c) Is the applicant currently on anti-epileptic medication? If Yes, please fill in the medication section 8, page 6. (d) If no longer treated, when did treatment end? (e) Has the applicant had a brain scan? If Yes, please give details in section 9, page 7. (f) Has the applicant had an EEG? If you have answered Yes to any of above, you must supply medical reports.	If No, go to 1c If Yes, please give date started on insulin. (b) Are there at least 3 continuous months of blood glucose readings stored on a memory meter or meters? If No, please give details in section 9, page 7. (c) Other injectable treatments? (d) A Sulphonylurea or a Glinide? (e) Oral hypoglycaemic agents and diet? If Yes to any of (a) to (e), please fill in the medication section 8, page 6. (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. Has the applicant experienced dissociative/'non-epileptic' seizures? (a) If Yes, please give date of most recent episode. (b) If Yes, have any of these episode(s) occurred or are they considered likely to occur whilst driving?	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. Stroke or TIA? If Yes, give date. (a) Has there been a full recovery?	3. (a) Has the applicant ever had a hypoglyaemic episode? (b) If Yes, is there full awareness of hypoglycaemia?
 (b) Has a carotid ultrasound been undertaken? (c) If Yes, was the carotid artery stenosis >50% in either carotid artery? (d) Is there a history of multiple strokes/TIAs? 4. Sudden and disabling dizziness or vertigo 	4. Is there a history of hypoglycaemia in the last 12 months requiring the assistance of another person? If Yes, please give details and dates below.
within the last year with a liability to recur?	
5. Subarachnoid haemorrhage (non-traumatic)?6. Significant head injury within the	5. Is there evidence of: Yes No
last 10 years?	(a) Loss of visual field? (b) Severe peripheral neuropathy, sufficient
7. Any form of brain tumour?	to impair limb function for safe driving? If Yes, please give details in section 9, page 7.
8. Other intracranial pathology?9. Chronic neurological disorder(s)?	6. Has there been laser treatment or Yes No
10. Parkinson's disease?	intra-vitreal treatment for retinopathy?
11. Blackout, impaired consciousness or loss of awareness within the last 10 years?	If Yes, please give most recent date of treatment.
Applicant's full name	Date of birth

3 Cardiac			Peripheral arterial disease (excluding Buerger's disease)	
a Coronary artery disease			aortic aneurysm/dissection	
Is there a history or evidence of coronary artery disease? If No, go to section 3b, Cardiac arrhythmia If Yes, please answer all questions below and enclose relevant hospital notes.	Yes	ar ac If	there a history or evidence of peripheral terial disease (excluding Buerger's disease), ortic aneurysm or dissection? No, go to section 3d, Valvular/congenital heat Yes, please answer all questions below and aclose relevant hospital notes.	Yes No rt disease
Has the applicant ever had an episode of angina?	Yes	No	Peripheral arterial disease? (excluding Buerger's disease)	Yes No
If Yes, please give the date of the last known attack.	Yes	No a		Yes No
2. Acute coronary syndrome including myocardial infarction? If Yes, please give date.	7	2.	Does the applicant have claudication? If Yes, would the applicant be able to undertake 9	
3. Coronary angioplasty (PCI)? If Yes, please give date of most recent	Yes	No 3.	minutes of the standard Bruce Protocol ETT? Aortic aneurysm?	Yes No
intervention.4. Coronary artery bypass graft surgery?	Yes	No	If Yes: (a) Site of aneurysm: Thoracic Abdominal (b) Has it been repaired successfully?	
 If Yes, please give date. If Yes to any of the above, are there any physical health problems or disabilities (e.g. mobility, arthritis or COPD) that would ma the applicant unable to undertake 9 minutes of standard Bruce Protocol ETT? Please give detail 	ke the	No	(c) Please provide latest transverse aortic diameter measurement and date obtained using measurement and date boxes.	
			Dissection of the aorta repaired successfully? If Yes, please provide copies of all reports including those dealing with any surgical treating.	Yes No
b Cardiac arrhythmia		5.	Is there a history of Marfan's disease? If Yes, please provide relevant hospital notes.	Yes No
Is there a history or evidence of cardiac arrhythmia?		5.	If Yes, please provide relevant hospital notes.	Yes No
Is there a history or evidence of	ase	No d	If Yes, please provide relevant hospital notes.	Yes No Yes No
Is there a history or evidence of cardiac arrhythmia? If No, go to section 3c, Peripheral arterial disea If Yes, please answer all questions below and en relevant hospital notes. 1. Has there been a significant disturbance of cardiac rhythm? (e.g. sinoatrial disease, significant atrio-ventricular conduction defect	ase close	No dis va	If Yes, please provide relevant hospital notes. Valvular/congenital heart disease there a history or evidence of livular or congenital heart disease?	Yes No
Is there a history or evidence of cardiac arrhythmia? If No, go to section 3c, Peripheral arterial disease If Yes, please answer all questions below and en relevant hospital notes. 1. Has there been a significant disturbance of cardiac rhythm? (e.g. sinoatrial disease, significant atrio-ventricular conduction defect atrial flutter or fibrillation, narrow or broad complex tachycardia) in the last 5 years?	ase close	No dis valified if rei	Valvular/congenital heart disease there a history or evidence of livular or congenital heart disease? No, go to section 3e, Cardiac other Yes, answer all questions below and provide	
Is there a history or evidence of cardiac arrhythmia? If No, go to section 3c, Peripheral arterial disease If Yes, please answer all questions below and en relevant hospital notes. 1. Has there been a significant disturbance of cardiac rhythm? (e.g. sinoatrial disease, significant atrio-ventricular conduction defect atrial flutter or fibrillation, narrow or broad complex tachycardia) in the last 5 years? 2. Has the arrhythmia been controlled satisfactorily for at least 3 months?	ase close	No dis va lf lf re No 1.	If Yes, please provide relevant hospital notes. Valvular/congenital heart disease there a history or evidence of divular or congenital heart disease? No, go to section 3e, Cardiac other Yes, answer all questions below and provide levant hospital notes.	Yes No
Is there a history or evidence of cardiac arrhythmia? If No, go to section 3c, Peripheral arterial disea If Yes, please answer all questions below and en relevant hospital notes. 1. Has there been a significant disturbance of cardiac rhythm? (e.g. sinoatrial disease, significant atrio-ventricular conduction defect atrial flutter or fibrillation, narrow or broad complex tachycardia) in the last 5 years? 2. Has the arrhythmia been controlled	yes	No dis va if if rei	Valvular/congenital heart disease there a history or evidence of alvular or congenital heart disease? No, go to section 3e, Cardiac other Yes, answer all questions below and provide levant hospital notes. Is there a history of congenital heart disease?	Yes No
Is there a history or evidence of cardiac arrhythmia? If No, go to section 3c, Peripheral arterial disease If Yes, please answer all questions below and en relevant hospital notes. 1. Has there been a significant disturbance of cardiac rhythm? (e.g. sinoatrial disease, significant atrio-ventricular conduction defect atrial flutter or 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 (Implanted Cardiac Defibrillator) or biventricular pacemaker with defibrillator/cardiac resynchronisation therapy defibrillator (CRT-D type) been implanted? 4. Has a pacemaker or a biventricular pacemaker/cardiac resynchronisation therapy pacemaker (CRT-P type) been implanted?	yes Yes	No Is valif If rei No I. No III If rei III If rei III If rei III If rei III II	Valvular/congenital heart disease there a history or evidence of alvular or congenital heart disease? No, go to section 3e, Cardiac other Yes, answer all questions below and provide levant hospital notes. Is there a history of congenital heart disease? Is there a history of heart valve disease? Is there a history of aortic stenosis? If Yes, please provide relevant reports	Yes No Yes No Yes No
Is there a history or evidence of cardiac arrhythmia? If No, go to section 3c, Peripheral arterial disease If Yes, please answer all questions below and en relevant hospital notes. 1. Has there been a significant disturbance of cardiac rhythm? (e.g. sinoatrial disease, significant atrio-ventricular conduction defect atrial flutter or 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 (Implanted Cardiac Defibrillator) or biventricular pacemaker with defibrillator/ cardiac resynchronisation therapy defibrillator (CRT-D type) been implanted? 4. Has a pacemaker or a biventricular pacemaker/ cardiac resynchronisation therapy pacemaker (CRT-P type) been implanted? If Yes: (a) Please give date of implantation.	yes Yes Yes	No Is valif If rei No I. No III If rei III If rei III If rei III If rei III II	If Yes, please provide relevant hospital notes. Valvular/congenital heart disease there a history or evidence of divular or congenital heart disease? No, go to section 3e, Cardiac other Yes, answer all questions below and provide levant hospital notes. Is there a history of congenital heart disease? Is there a history of heart valve disease? Is there a history of aortic stenosis? If Yes, please provide relevant reports (including echocardiogram). Is there history of embolic stroke?	Yes No Yes No Yes No Yes No
Is there a history or evidence of cardiac arrhythmia? If No, go to section 3c, Peripheral arterial disease If Yes, please answer all questions below and en relevant hospital notes. 1. Has there been a significant disturbance of cardiac rhythm? (e.g. sinoatrial disease, significant atrio-ventricular conduction defect atrial flutter or 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 (Implanted Cardiac Defibrillator) or biventricular pacemaker with defibrillator (CRT-D type) been implanted? 4. Has a pacemaker or a biventricular pacemaker (CRT-P type) been implanted? If Yes: (a) Please give date	yes Yes Yes	No Is value of the state of the	Valvular/congenital heart disease there a history or evidence of dvular or congenital heart disease? No, go to section 3e, Cardiac other Yes, answer all questions below and provide devant hospital notes. Is there a history of congenital heart disease? Is there a history of heart valve disease? Is there a history of aortic stenosis? If Yes, please provide relevant reports (including echocardiogram). Is there history of embolic stroke? Does the applicant currently have	Yes No Yes No Yes No Yes No Yes No

e Cardiac other			ided, give details in				eport
Is there a history or evidence of heart failure? If No, go to section 3f, Cardiac channelopathies	Yes N	2.	Has an exercise I (or planned)?	ECG been under	taken	Yes	No
If Yes, please answer all questions and enclose relevant hospital notes. 1. Please provide the NYHA class, if known.		3.	Has an echocard (or planned)?	iogram been und	dertaken	Yes	No
2. Established cardiomyopathy?If Yes, please give details in section 9, page 7.	Yes N	No	(a) If undertaken, fraction great	, is or was the le er than or equal	ft ejection to 40%?		
3. Has a left ventricular assist device (LVAD) or other cardiac assist device been implanted?	Yes N	4. No	Has a coronary a (or planned)?	ngiogram been u	undertaken	Yes	No
4. A heart or heart/lung transplant?	Yes N		Has a 24 hour E0 (or planned)?	CG tape been un	dertaken	Yes	No
5. Untreated atrial myxoma?	Yes N		Has a loop record (or planned)?	der been implant	ted	Yes	No
f Cardiac channelopathies					VI I I		_
Is there a history or evidence of the following conditions? If No, go to section 3g, Blood pressure			Has a myocardia echo study or ca (or planned)?			Yes	No
1. Brugada syndrome?	Yes N	No 4	Psychiatric	illness			
2. Long QT syndrome? If Yes to either, please give details in section 9, page 7 and enclose relevant hospital notes.	Yes N	illno If N	here a history or e ess within the last lo, go to section es, please answe	3 years? 5, Substance n	nisuse	Yes	No
g Blood pressure			Significant psychi past 6 months? If	iatric disorder wit	thin the	Yes	No
All questions must be answered. If resting blood pressure is 180 mm/Hg systolic or rand/or 100mm/Hg diastolic or more, please take a 2 readings at least 5 minutes apart and record the bases.	further	2.	Psychosis or hype	omania/mania wi	ithin the	Yes	No
of the 3 readings in the box provided.		_	past 12 months, ir		·	Yes	No
1. Please record today's best resting blood pressure reading.	Yes No		(a) Dementia or cognitive impairment?(b) Are there concerns which have resulted in ongoing investigations for such				
Is the applicant on anti-hypertensive treatment? If Yes, please provide three previous readings with dates if available.			possible diag	noses?	sucii		
/ DDMM	ΥΥ	5	Substance	misuse			
	Y Y Y Y	or (here a history of d dependence? lo, go to section 'es, please answe	6, Sleep disord	lers	Yes	No
3. Is there a history of malignant hypertension? If Yes, please give details in section 9,	Yes N	No 1.	Is there a history in the past 6 year	of alcohol depen		Yes	No
page 7 (including date of diagnosis and any treatment of the cardiac investigations	nent eta	c).	(a) Is it controlled (b) Has the applic detoxification	cant undergone a	ın alcohol		
Have any cardiac investigations been	Yes N	No	If Yes, give date s		D D M N	1 Y	Υ
undertaken or planned? If No, go to section 4, Psychiatric illness If Yes, please answer questions 1 to 7.		2.	Persistent alcohol (a) Is it controlled	-	st 3 years?	Yes	No
1. Has a resting ECG been undertaken? 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 in section 9,	Yes N	3.	Use of illegal drugs of prescription me (a) If Yes, the typ (b) Is it controlled (c) Has the applic treatment program of the	dication in the las e of substance r d? cant undertaken a	t 6 years? misused?	Yes	No
			If Yes, give date s		DDMM	1 Y	Y
Applicant's full name	\vdash	+++	++++	Date of birth	DDMN	1 V	\vee

6	Sleep disorders	6. Does the applicant have a history of liver disease of any origin?
1.	Is there a history or evidence of Obstructive Yes No Sleep Apnoea Syndrome or any other medical condition causing excessive sleepiness?	If Yes, is this the result of alcohol misuse? If Yes, please give details in section 9, page 7.
	If No, go to section 7, Other medical conditions. If Yes, please give diagnosis and answer all questions below.	7. Is there a history of renal failure? If Yes, please give details in section 9, page 7.
	a) If Obstructive Sleep Apnoea Syndrome, please indicate the severity:	8. Does the applicant have severe symptomatic Yes respiratory disease causing chronic hypoxia?
	Mild (AHI <15) Moderate (AHI 15 - 29) Severe (AHI >29) Not known If another measurement other than AHI is used, it	9. Does any medication currently taken cause the applicant side effects that could affect safe driving? If Yes, please fill in section 8, Medication and give symptoms in section 9, page 7.
	must be one that is recognised in clinical practice as equivalent to AHI. Please give details in section 9.	10. Does the applicant have any other medical Yes No condition that could affect safe driving?If Yes, please provide details in section 9, page 7.
	b) Please answer questions (i) to (vi) for all sleep conditions.	8 Medication
	(i) Date of diagnosis: D D M Y Y Y Yes No (ii) Is it controlled successfully? (iii) If Yes, please state treatment.	Please provide details of all current medication including eye drops (continue on a separate sheet if necessary).
	(1)	Medication Dosage
	Yes No	Reason for taking:
	(iv) Is applicant compliant with treatment?(v) Please state period of control:	Approximate date started (if known):
	years months (vi) Date of last review.	Medication Dosage
	(vi) Bate of last follow.	Reason for taking:
7	Other medical conditions	Approximate date started (if known):
1.	Is there a history or evidence of narcolepsy? Yes No	Medication Dosage
2.	Is there currently any functional impairment Yes No that is likely to affect control of the vehicle?	Reason for taking: Approximate date started (if known): DDMMYY
3.	Is there a history of bronchogenic carcinoma Yes No or other malignant tumour with a significant liability to metastasise cerebrally?	Medication Dosage
4.	Is there any illness that may cause significant Yes No fatigue or cachexia that affects safe driving?	Reason for taking: Approximate date started (if known): DDMMYY
5.	Is the applicant profoundly deaf? Yes No	Medication Dosage
	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?	Reason for taking:
		Approximate date started (if known):
Apı	olicant's full name	Date of birth

9 Further details	10 Consultants' details
Please send us copies of relevant hospital notes. Do not send any notes not related to fitness to drive. Use the	Please provide details of type of specialists or consultants, including address.
space below to provide any additional information.	Consultant in
	Reason for attendance
	Name
	Address
	Date of last appointment:
	Consultant in
	Reason for attendance
	Name
	Address
	Date of last appointment:
	If more consultants seen give details on a separate sheet.
	11 Examining doctor's signature
	and stamp
	To be filled in by the doctor carrying out the examination.
	Please make sure all sections of the form have been filled in. The form will be returned to you if you do not do this.
	I confirm that this report was filled in by me at examination and I have taken the applicant's history into account. I also confirm that I am currently GMC registered and licensed to practise in the UK or I am a doctor who is medically registered within the EU, if the report was filled in outside the UK.
	Signature of examining doctor
	Date of signature
	Doctor's stamp
Applicant's full name	Date of birth D D M M Y Y

Notes

- If the doctor is unable to fully and accurately complete the Vision assessment you must arrange for an optician or optometrist to complete the assessment. Send the completed report (Vision and Medical assessment), application form and your driving licence to North Yorkshire Council.
- The council will not be responsible for any fees you have paid to a doctor and/or optician or optometrist, even if your application is ultimately refused.
- You must take a form of photographic identity to the examination, for example your passport or driving licence.
- Both examinations must have taken place and have been signed and dated by the doctor and optometrist/optician no more than one month before the date of the application being submitted to the council.

Information for the doctor

- Please only complete the vision assessment if you are able to fully and accurately complete ALL
 questions. If you are unable to do this you must tell the applicant that they will need to arrange
 to have this part of the assessment completed by an optician or optometrist.
- Please ensure that you confirm the applicant's identity before examination. They have been advised of the need to produce photographic identification.
- Please examine the applicant fully and complete all relevant sections of the medical assessment, including a surgery/practice stamp in section 11.
- You must have regard to any information contained within the applicant's medical history when
 you fill in the report. Details of any condition which has not been covered by the report should be
 given in section 9.
- The applicant will be liable for any costs incurred.
- You may find it helpful to read the DVLA's Guide for medical professionals here: https://www.gov.uk/dvla/fitnesstodrive

Information for the optician/optometrist

- The vision assessment can be completed by a doctor, optician or optometrist. In some cases the doctor may not be able to fully complete the report and will have advised the applicant to arrange an appointment with an optician/optometrist.
- Please ensure that you confirm the applicant's identity before examination. They have been advised of the need to produce photographic identification.
- Please complete all relevant sections of the vision assessment.
- Please make sure you answer all questions and provide any additional information in the box provided for details. Please include any consultant or specialist details.
- The applicant will be liable for any costs incurred.
- You may find it helpful to read the DVLA's Guide for medical professionals here: https://www.gov.uk/dvla/fitnesstodrive