

MEDICAL ASSESSMENT

ASSOCIATED WITH AN APPLICATION FOR A LICENCE TO DRIVE A
HACKNEY CARRIAGE OR PRIVATE HIRE VEHICLE

Notes for the Applicant

This medical assessment must be carried out by a General Practitioner in the medical practice to which you are registered or by a GP or Doctor who has access to your **FULL** medical records which must be reviewed prior to completion of this assessment.

The vision assessment must be completed by a doctor or optician/optometrist. Some doctors will be able to fill in both vision and medical assessment section of the report. If your doctor is unable to fully answer all of the questions on the vision assessment you must have it completed by an optician/optometrist.

IMPORTANT: ASSESSMENTS MUST NOT TAKE PLACE MORE THAN TWO CALENDAR MONTHS BEFORE THE DATE A LICENCE IS GRANTED OR RENEWED.

Applicant's Details: (to be completed in the presence of the GP or Doctor carrying out the examination)

Full name: Date of Birth: Age:

Address:

Post Code:

Contact telephone number:

Email:

Applicant's consent and declaration

I authorise my General Practitioner(s) or Doctor to provide the information requested on this form relevant to my fitness to drive a licensed hackney carriage or private hire vehicle to Wirral Council in order to assess my fitness to hold a hackney carriage or private hire driver licence.

I declare that to the best of my knowledge and belief all information given by me to my GP or Doctor in connection with this examination is true.

Signed:

Date:

General Practitioner/Doctor

This form must be completed in full by the applicant's own GP or Doctor or a GP or Doctor who has reviewed the applicant's medical records. Please answer all questions signing each page and once completed sign the declaration at the end.

Wirral Council's policy on medical fitness requires that hackney carriage and private hire drivers meet Group 2 Medical Standards, as set out in the DVLA publication '*Assessing fitness to drive - a guide for medical professionals*'.

This guide makes reference to current best practice guidance contained in the booklet 'Fitness to Drive' which recommends the medical standard applied by DVLA in relation to bus and lorry drivers should also be applied by local authorities to hackney carriage and private hire drivers.

(a)	Is the applicant a registered patient of the surgery / medical centre at which you practice as a registered medical practitioner?	YES	NO
(b)	Have you reviewed the above applicant's medical records? If reviewing a printout of the medical records please give date of printout:	YES	NO

Section 1

Vision Assessment – to be completed by the GP or Optician/Optomtrist

Please see the current DVLA guidance so that you can decide whether you are able to fully complete the vision assessment at www.gov.uk/current-medical-guidelines-dvla-guidance-for-professionals

1	Please confirm the scale you are using to express the driver's visual acuities: ☐ Snellen ☐ Snellen expressed as a decimal ☐ LogMAR				
			YES	NO	
2	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)			☐	☐
3	Were corrective lenses worn to meet this standard? If Yes please indicate if: ☐ Glasses ☐ Contact lenses ☐ Both			☐	☐
4	Uncorrected		Corrected (using the prescription worn for driving)		
	Right		Left		
	Right		Left		
5	If glasses (not contact lenses) are worn for driving, is the corrective power greater than +8 dioptres in any meridian of either lens?			☐	☐
6	If a correction is worn for driving, is it well tolerated?			☐	☐
7	Is there a history of any medical condition that may affect the applicant's binocular field of vision (central and / or peripheral)?			☐	☐
8	Is there diplopia (controlled or uncontrolled)?			☐	☐
9	Does the applicant, on questioning, report symptoms of intolerance to glare and / or impaired contrast sensitivity and / or impaired twilight vision?			☐	☐
10	Does the applicant have any other ophthalmic condition?			☐	☐

If **YES** to questions 7, 8, 9 or 10 please give details in **Section 7**.

If eye examination has been completed by an Optician or Optometrist please give details below:

Name:

Address:

Contact telephone number:

Section 2

NERVOUS SYSTEM

	Is there any history of, or evidence of, any neurological disorder? If No , go to section 3				Yes ☐	No ☐	
1	Has the applicant had any form of seizure? If YES please answer questions a – f below.				Yes ☐	No ☐	
	a	Has the applicant had more than one attack?			☐	☐	
	b	Please give date of first and last attack:	<i>First attack</i>	DD MM YY	<i>Last attack</i>	DD MM YY	
	c	Is the applicant currently on anti-epileptic medication? If YES please give details of current medication in section 7 .				☐	☐
	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 provide date and details in Section 7 .			☐	☐	
	f	Has the applicant had an EEG? If YES please provide date and details in Section 7			☐	☐	
2	Is there a history of blackout or impaired consciousness within the last 5 years? If YES please give dates and details at Section 7 :				☐	☐	
3	Does the applicant suffer from narcolepsy? If YES please give dates and details in Section 7 .				☐	☐	
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 give dates and full details in section 7 .						
	a	Stroke / TIA If YES please give date: DD MM YY			☐	☐	
		Has there been a FULL recovery?			☐	☐	
		Has a carotid ultrasound been undertaken?			☐	☐	
		If YES , was the carotid artery stenosis >50% in either carotid artery?			☐	☐	
	b	Sudden and disabling dizziness/vertigo within the last one year with a liability to recur			☐	☐	
	c	Subarachnoid haemorrhage			☐	☐	
	d	Serious traumatic brain injury within the last 10 years			☐	☐	
	e	Any form of brain tumour			☐	☐	
	f	Other brain surgery or abnormality			☐	☐	
	g	Chronic neurological disorders			☐	☐	
	h	Parkinson's disease			☐	☐	

Section 3

DIABETES MELLITUS

Does the applicant have diabetes mellitus?

If **NO** please go to Section 4.If **YES** please answer the following questions.**Yes**☐**No**☐

1	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 in a memory meter? If NO , please give details in Section 7	☐	☐
	c	Other injectable treatments?	☐	☐
	d	A Sulphonylurea or a Glinide?	☐	☐
	e	Oral hypoglycaemic agents and diet? If YES please provide details of medication:	☐	☐
	f	Diet only?	☐	☐
If YES to any of (a) – (e) above, please give details in Section 7				
2	a	Does the applicant test blood glucose at least twice every day?	☐	☐
	b	Does the applicant test at times relevant to 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?		☐	☐
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 or 3 – 5 above, please give details in Section 7				
6	Has there been any laser treatment or intra-vitreous for retinopathy? If YES please give date(s) of treatment: DD MM YY		☐	☐

Section 4				
<u>CARDIAC</u>				
4A	CORONARY ARTERY DISEASE			
Is there a history of, or evidence of, Coronary Artery Disease? If NO please go to Section 4B. If YES please answer all questions below and give details at Section 7 of the form.			Yes ☐	No ☐
1	Acute coronary syndrome including myocardial infarction? If YES please give date(s): DD MM YY	☐	☐	
2	Coronary artery by-pass graft surgery? If YES please give date(s): DD MM YY	☐	☐	
3	Coronary Angioplasty (PCI)? If YES please give date of most recent intervention: DD MM YY	☐	☐	
4	Has the applicant suffered from angina? If YES please give the date of the last known attack: DD MM YY	☐	☐	
5	If YES to any of the above, are there any physical health problems (eg. Mobility/arthritis. COPD) that would make the applicant unable to undertake 9 minutes of the standard Bruce Protocol ETT?	☐	☐	
4B	CARDIAC ARRHYTHMIA			
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 7 .			Yes ☐	No ☐
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 last 5 years?		☐	☐
2	Has the arrhythmia been controlled satisfactorily for at least 3 months?		☐	☐
3	Has an ICD or biventricular pacemaker (CRST-D type) been implanted?		☐	☐
4	Has a pacemaker been implanted? If YES :		☐	☐
	a	Please supply date:		
	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					
Is there a history or evidence of ANY of the conditions listed at 1 – 5 below? If NO go to Section 4D . If YES please answer the questions below and give details in Section 7				Yes ☐	No ☐	
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 (please tick):	Thoracic ☐	Abdominal ☐		
	b	Has it been repaired successfully?			☐	☐
	c	Is the transverse diameter currently >5.5cm?			☐	☐
		If NO please provide latest measurement:		Date obtained: DD MM YY		
4	Dissection of the Aorta repaired successfully. If YES , please provide details in Section 7			☐	☐	
5	Is there history of Marfan's disease? If YES , please provide details in Section 7			☐	☐	
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 7						
1	Is there a history of congenital heart disorder?			☐	☐	
2	Is there a history of heart valve disease?			☐	☐	
3	Is there a history of aortic stenosis?			☐	☐	
4	Is there any history of embolism? (not pulmonary embolism)			☐	☐	
5	Does the applicant currently have significant symptoms?			☐	☐	
6	Has there been any progression since the last licence application? (if relevant)			☐	☐	
4E	CARDIAC OTHER					
Does the applicant have a history of ANY of the following conditions? If NO go to Section 4F. If YES please answer ALL questions below and give details in Section 7				Yes ☐	No ☐	
a	A history of, or evidence of, heart failure?			☐	☐	
b	Established cardiomyopathy?			☐	☐	
c	Has a left ventricular assist device (LVAD) been implanted?			☐	☐	
d	A heart or heart/lung transplant?			☐	☐	
e	Untreated atrial myxoma?			☐	☐	

4F	CARDIAC CHANNELOPATHIES			
Is there a history of, or evidence of either of the following conditions? If No , go to section 4G			Yes ☐	No ☐
1	Brugada syndrome?		☐	☐
2	Long QT syndrome?		☐	☐
If Yes to either, please give details in section 7				
4G	BLOOD PRESSURE (This section must be filled in for all applicants)			
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:				
1	B.P. reading:	Date:	DD MM YY	
2	B.P. reading:	Date:	DD MM YY	
3	B.P. reading:	Date:	DD MM YY	
3	Is there history of malignant hypertension? If Yes , please provide details in section 7 (including date of diagnosis and any treatment etc)		Yes ☐	No ☐
4H	CARDIAC INVESTIGATIONS (This section must be filled in for all applicants)			
Have any cardiac investigations been undertaken or planned? If No , go to section 5 If Yes , please answer questions 1 - 6			Yes ☐	No ☐
1	Has a resting ECG been undertaken? If YES does it show:		Yes ☐	No ☐
a	Pathological Q waves?		☐	☐
b	Left bundle branch block?		☐	☐
c	Right bundle branch block?		☐	☐
If Yes to a, b or c please provide details in section 7				
2	Has the exercise ECG been undertaken (or planned)?		☐	☐
If YES please provide date and give details in Section 7 DD MM YY				
3	Has an echocardiogram been undertaken (or planned)?		☐	☐
a	If YES please give date and give details in Section 7 DD MM YY			
b	If undertaken is/was the left ventricular ejection fraction greater than or equal to 40%?		☐	☐
4	Has a coronary angiogram been undertaken (or planned)?		☐	☐
If YES please provide date and give details in Section 7 : DD MM YY				

5	Has a 24 hour ECG tape been undertaken (or planned)?	☐	☐
	If YES please provide date and give details in Section 7 DD MM YY		
6	Has a Myocardial Perfusion Scan or Stress Echo study been undertaken (or planned)?	☐	☐
	If YES please provide date and give details in Section 7 DD MM YY		

Section 5

PSYCHIATRIC ILLNESS

Is there a history of, or evidence of ANY of the conditions listed at 1 – 9 below? If NO please go to Section 6.		Yes ☐	No ☐
If YES please answer the following questions and give date(s), prognosis, period of stability and details of medication, dosage and any side effects in Section 7 . (Please enclose relevant notes). (If applicant remains under specialist clinic(s) please give details in Section 7).			
1	Significant psychiatric disorder within the past 6 months?	☐	☐
2	Psychosis or hypomania/mania within the past 3 years, including psychotic depression?	☐	☐
3	Dementia or cognitive impairment?	☐	☐
4	Persistent alcohol misuse in the past 12 months?	☐	☐
5	Alcohol dependence in the past 3 years?	☐	☐
6	Does the applicant show any evidence of being addicted to the excessive use of alcohol?	☐	☐
7	Persistent drug misuse in the past 12 months?	☐	☐
8	Does the applicant show any evidence of being addicted to the excessive use of drugs?	☐	☐
9	Drug dependency in the past 3 years?	☐	☐

Section 6

GENERALPlease answer all questions in this section. If you answer **YES** to any question please give full details in **Section 7**.

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. Please give details in section 7		
	b	Please answer questions (i) to (vi) for all sleep conditions	
	(i)	Date of diagnosis: DD MM YY	
	(ii)	Is it controlled successfully?	Yes ☐ No ☐
	(iii)	If Yes please state treatment:	
	(iv)	Is patient compliant with treatment	Yes ☐ No ☐
	(v)	Please state period of control:	
	(vi)	Date of last review: DD MM YY	
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, eg. a textphone?	Yes ☐	No ☐
6	Does the applicant have a history of liver disease of any origin? If YES please provide details in Section 7 .	Yes ☐	No ☐
7	Is there any history of renal failure? If YES please provide details in Section 7 .	Yes ☐	No ☐
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? If YES please provide details of medication and symptoms in Section 7	Yes ☐	No ☐
10	Does the applicant have any other medical condition that could affect safe driving? If YES please provide details in Section 7	Yes ☐	No ☐

Section 7

Additional Information

PLEASE ENSURE YOU COMPLETE AND SIGN THE LAST PAGE OF THIS MEDICAL ASSESSMENT

General Practitioner Declaration:

Please read the following carefully before completing, signing and dating the declaration.

If the applicant is not a registered patient with your practice or you have not reviewed their medical record's then **DO NOT** complete the declaration.

I certify that;

- I have today undertaken a medical examination of the applicant for the purpose of assessing their fitness to act as a driver of a hackney carriage or private hire vehicle under the **DVLA Group 2 Medical Standards**
- I have reviewed the applicant's medical records and that in my opinion nothing therein contradicts or tends to contradict the information given to me by the applicant.
- The medical examination today is satisfactory. From the applicant's medical records and from today's examination, I know of no medical reason where the applicant would be advised to inform the DVLA with regards to driver licensing requirements under Group 2 standards.

Surgery / Medical Centre Name:

Surgery / Medical Centre Stamp:

FORM WILL NOT BE ACCEPTED WITHOUT AN OFFICIAL STAMP

Surgery / Medical Centre Address:

GP's Name:

PLEASE PRINT IN BLOCK CAPITALS

GP's Signature:

Date: