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# MEDICAL EXAMINATION REPORT GROUP 2 LICENCE ENTITLEMENT FOR HACKNEY CARRIAGE AND PRIVATE HIRE DRIVERS

PRESTON CITY COUNCIL LICENSING SERVICES ENVIRONMENTAL HEALTH DEPARTMENT TOWN HALL LANCASTER ROAD PRESTON PR1 2RL Tel: 01772 906910 Email: taxilicensing@preston.gov.uk



## Guidance for applicants for a private hire / hackney carriage driver's licence

### When is a medical required?

- All applications for a hackney carriage and / or private hire driver's licence must be accompanied by a satisfactory medical report to the DVLA Group 2 medical standards. This is regardless of the age of the applicant.
- A medical will be required on submission of a new application and every 3 years thereafter (on renewal), until the age of 65. From age 65 onwards a medical will be required annually.
- Some medical conditions will need an annual medical certificate or an annual letter from a Doctor indicating that a current medical condition is under control and remains stable.

\*Please check that this medical examination report form ("this form") is the most **recent version** by visiting the following web address and checking the version date: <u>www.preston.gov.uk/taxidriver</u>. Information about the Group 2 medical standards can be found in the DVLA's leaflet '**INF4D**'.

## Completion of this form

This form is based on the DVLA D4 medical examination form for a Group 2 licence. The medical must be completed by a GP (Doctor) that has access to the applicant's medical record.

This form should be completed in block capitals using **black ink**. The applicant must complete sections 13 and 14 of this form in front of the GP (Doctor) who is carrying out the medical assessment.

### Guidance for the GP (Doctor) completing this form

Please check the applicant's identity before you proceed with the medical assessment and specify the type of identification provided by the applicant on page 8 of this form. Also, complete the applicant's full name and date of birth at the bottom of each page to this form. Please answer all questions, including sections 11 and 12. Please ensure you **fully examine** the applicant as well as taking the applicant's history.

The medical assessment includes a **vision assessment**. If you are unable to fully answer the vision assessment questions the applicant must have this part of the medical completed by an optician or optometrist.

Applicant's Full Name: \_\_\_\_\_\_ Applicant's Date of Birth: DD/MM/YYYY

## Medical examination report

# Vision assessment

To be filled in by an optician, optometrist or doctor

1.	Please confirm (/) the scale you are using to express the applicant's visual acuities. Snellen Snellen expressed as a decimal LogMAR	<ul> <li>5. Does the applicant report symptoms of any of the following that impairs their ability to drive?</li> </ul>
2.	<ul> <li>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.</li> <li>(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</li> </ul>	<ul> <li>Please indicate below and give full details in Q7 below.</li> <li>(a) Intolerance to glare (causing incapacity rather than discomfort) and/or</li> <li>(b) Impaired contrast sensitivity and/or</li> <li>(c) Impaired twilight vision</li> </ul>
	standard is not met, the applicant may need further assessment by an optician. R   L   Yes No     (b) Are corrective lenses worn for driving?   Image: Constraint of the second se	<ul> <li>6. Does the applicant have any other ophthalmic condition affecting their visual acuity or visual field?</li> <li>If Yes, please give full details in Q7 below.</li> </ul>
	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
	R   L     (c) What kind of corrective lenses are worn to meet this standard?     Glasses   Contact lenses     Both together	
	<ul> <li>(d) If glasses are worn for driving, is the corrective power greater than plus (+)8 dioptres in any meridian of either lens?</li> <li>(e) If correction is worn for driving, is it well tolerated? If No, please give full details in Q7.</li> </ul>	Name of examining doctor, optician or optometrist undertaking vision assessment
3.	Is there a history of any <sub>3</sub> medical condition that may affect the applicant's binocular field of vision (central and/or peripheral)? If Yes, please give full details below.	taken into consideration. Signature of examining doctor, optician or optometrist
	If formal visual field testing is considered necessary, DVLA will commission this at a later date.	Date of signature Please provide your GOC or GMC number Doctor, optometrist or optician's stamp
4.	Is there diplopia? Yes No (a) Is it controlled? In the controlled of the control	
Ар	olicant's full name Please do not o	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	
Is the disor <b>If No</b> If Yes	se tick ✓ the appropriate boxes ere a history or evidence of any neurological der (see conditions in questions 1 to 11 below)? S, go to section 2, Diabetes mellitus s, please answer all questions below and enclose relevant bital notes.	If N	Yes the applicant have diabetes mellitus?	
1.	<ul> <li>Yes No</li> <li>Has the applicant had any form of seizure?</li> <li>(a) Has the applicant had more than one seizure episode?</li> <li>(b) If Yes, please give date of first and last episode.</li> <li>First episode</li> <li>Last episode</li> <li>Last episode</li> <li>If Yes, please fill in the medication section 8, page 6.</li> <li>(d) If no longer treated, when did treatment end?</li> <li>(e) Has the applicant had a brain scan?</li> <li>If Yes, please give details in section 9, page 7.</li> <li>(f) Has the applicant had an EEG?</li> </ul>	2.	If No, go to 1c If Yes, please give date started on insulin. (b) Are there at least 6 continuous weeks 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? (a) Does the applicant test blood glucose at least twice every day? (b) Does the applicant test at times relevant	□ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □
2.	If you have answered Yes to any of above, you must supply medical reports. Has the applicant experienced Yes No 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?		<ul> <li>(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 while driving)?</li> <li>(c) Does the applicant keep fast-acting carbohydrate within easy reach when driving?</li> <li>(d) Does the applicant have a clear understanding of diabetes and the necessary precautions for safe driving?</li> </ul>	
3.	Stroke or TIA? Yes No If Yes, give date. Yes a full recovery? (b) Has a carotid ultrasound been undertaken?	3.	<ul> <li>(a) Has the applicant ever had Yes a hypoglyaemic episode?</li> <li>(b) If Yes, is there full awareness of hypoglycaemia?</li> </ul>	No
4.	<ul> <li>(c) If Yes, was the carotid artery stenosis</li> <li>&gt;50% in either carotid artery?</li> <li>(d) Is there a history of multiple strokes/TIAs?</li> <li>Sudden and disabling dizziness or vertigo</li> </ul>	4.	Is there a history of hypoglycaemia Yes in the last 12 months requiring the assistance of another person? If Yes, please give details and dates below.	No
5.	within the last year with a liability to recur?         Subarachnoid haemorrhage (non-traumatic)?			
6.	Significant head injury within the last 10 years?	5.	Is there evidence of: Yes (a) Loss of visual field?	No
7.	Any form of brain tumour?		(b) Severe peripheral neuropathy, sufficient to impair limb function for safe driving?	
8.	Other intracranial pathology?		If Yes, please give details in section 9, page 7.	
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?		of treatment.	
App	plicant's full name		Date of birth	Y

3 Cardiac	c Peripheral arterial disease (excluding Buerger's disease)						
a Coronary artery disease	aortic aneurysm/dissection						
Is there a history or evidence of Yes coronary artery disease? If No, go to section 3b, Cardiac arrhythmia If Yes, please answer all questions below and enclose relevant hospital notes.	arterial disease (excluding Buerger's disease), aortic aneurysm or dissection? If No, go to section 3d, Valvular/congenital heart disease If Yes, please answer all questions below and enclose relevant hospital notes.						
1. Has the applicant ever had an episode of angina?	No           I. Peripheral arterial disease?         Yes         No           (excluding Buerger's disease)						
2. Acute coronary syndrome including Yes myocardial infarction?	No       2. Does the applicant have claudication?       Image: Claudication in the standard bruce is a standard bruce in the standard bruce is a standard bru						
3. Coronary angioplasty (PCI)? Yes If Yes, please give date of most recent intervention.	No Stee of angurary Therapia						
4. Coronary artery bypass graft surgery? Yes	No (a) Site of aneurysm: Thoracic Abdominal (b) Has it been repaired successfully? (c) Please provide latest transverse aortic diameter measurement and date obtained						
5. If Yes to any of the above, are there any yes physical health problems or disabilities (e.g. mobility, arthritis or COPD) that would make the applicant unable to undertake 9 minutes of the standard Bruce Protocol ETT? Please give details belo	using measurement and date boxes.						
	4. Dissection of the aorta repaired successfully? Yes No If Yes, please provide copies of all reports						
b Cardiac arrhythmia	5. Is there a history of Marfan's disease?       Yes       No         If Yes, please provide relevant hospital notes.       Image: Comparison of the second						
Is there a history or evidence of Yes cardiac arrhythmia?	d Valvular/congenital heart disease						
If No, go to section 3c, Peripheral arterial disease If Yes, please answer all questions below and enclose relevant hospital notes.	Is there a history or evidence of Yes No valvular or congenital heart disease?						
<ol> <li>Has there been a significant disturbance of cardiac rhythm? (e.g. sinoatrial disease, significant atrio-ventricular conduction defect, Yes</li> </ol>	If Yes, answer all questions below and provide relevant hospital notes.						
atrial flutter or fibrillation, narrow or broad complex tachycardia) in the last 5 years?	<b>1.</b> Is there a history of congenital heart disease?						
2. Has the arrhythmia been controlled Yes satisfactorily for at least 3 months?	No     Yes     No       2. Is there a history of heart valve disease?     Image: Comparison of the sector of the secto						
<b>3.</b> Has an ICD (Implanted Cardiac Defibrillator) or biventricular pacemaker with defibrillator/ cardiac resynchronisation therapy defibrillator (CRT-D type) been implanted?	No     Yes     No       If Yes, please provide relevant reports (including echocardiogram).     Image: Comparison of the second seco						
4. Has a pacemaker or a biventricular pacemaker/ cardiac resynchronisation therapy pacemaker (CRT-P type) been implanted?	No 4. Is there history of embolic stroke?						
If Yes: (a) Please give date of implantation.	5. Does the applicant currently have significant symptoms?     Yes     No						
<ul><li>(b) Is the applicant free of the symptoms that caused the device to be fitted?</li><li>(c) Does the applicant attend a pacemaker clinic regularly?</li></ul>	6. Has there been any progression (either clinically or on scans etc) since the last licence application?       Yes       No						
Applicant's full name	Date of birth						

#### e Cardiac other

Is there a history or evidence of heart failure?	Yes
If No, go to section 3f, Cardiac channelopathies	
If Yes, please answer all questions and enclose	

No

Yes No

Yes No

Yes No

Yes

Yes

Yes

1

No

No

No

No

Yes No

- relevant hospital notes.
  Please provide the NYHA class, if known.
  Established cardiomyopathy? Yes No If Yes, please give details in section 9, page 7.
- **3.** Has a left ventricular assist device (LVAD) or other cardiac assist device been implanted?
- 4. A heart or heart/lung transplant?
- 5. Untreated atrial myxoma?

#### f Cardiac channelopathies

Is there a history or evidence of the following conditions?

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- 1. Brugada syndrome?
- Long QT syndrome? If Yes to either, please give details in section 9, page 7 and enclose relevant hospital notes.

#### g Blood pressure

#### All questions must be answered.

If resting blood pressure is 180 mm/Hg systolic or more and/or 100mm/Hg diastolic or more, please take a further 2 readings at least 5 minutes apart and record the best of the 3 readings in the box provided.

1. Please record today's best resting blood pressure reading.

with dates if available

2. Is the applicant on anti-hypertensive treatment? Yes No If Yes, please provide three previous readings

/	D	D	M	М	Y	Y
/	D	D	M	M	Y	Y
/	D	D	M	М	Y	Y

**3.** Is there a history of malignant hypertension? Yes If Yes, please give details in section 9, page 7 (including date of diagnosis and any treatment etc).

#### h Cardiac investigations

Applicant's full name

Have any cardiac investigations been	Yes	
undertaken or planned?		
If No, go to section 4, Psychiatric illness		
If Yes, please answer questions 1 to 7.		

1. Is there a history of the following:						
(a) left bundle branch block (LBBB)						
	(b) right bundle branch block (RBBB)?					
	If yes to (a) or (b) please provide relevant					

	or (b), prodoc provide relevant	
report(s) or	comment in section 9, page 7	

## Note: If Yes to questions 2 to 6, please give dates in the boxes provided, give details in section 9, page 7 and provide relevant reports.

2.	Has an exercise ECG been undertaken (or planned)?	Yes	No
3.	Has an echocardiogram been undertaken (or planned)?	Yes	No
	(a) If undertaken, is or was the left ejection fraction greater than or equal to 40%?		
4.	Has a coronary angiogram been undertaken (or planned)?	Yes	No
5.	Has a 24 hour ECG tape been undertaken (or planned)?	Yes	No
6.	Has a loop recorder been implanted (or planned)?	Yes	No
7.	Has a myocardial perfusion scan, stress echo study or cardiac MRI been undertaken (or planned)?	Yes	No
4	Psychiatric illness		
illn If N	here a history or evidence of psychiatric ess within the last 3 years? <b>Io, go to section 5, Substance misuse</b> és, please answer all questions below.	Yes	No
1.	Significant psychiatric disorder within the past 6 months? If Yes, please confirm condition.	Yes	No
2.	Psychosis or hypomania/mania within the past 12 months, including psychotic depression?	Yes	No
3.	<ul><li>(a) Dementia or cognitive impairment?</li><li>(b) Are there concerns which have resulted in ongoing investigations for such possible diagnoses?</li></ul>	Yes	No
5	Substance misuse		
or (	here a history of drug/alcohol misuse dependence? <b>Io, go to section 6, Sleep disorders</b> íes, please answer all questions below.	Yes	No
1.	Is there a history of alcohol dependence in the past 6 years? (a) Is it controlled? (b) Has the applicant undergone an alcohol detoxification programme? If Yes, give date started:	Yes	No
2.	Persistent alcohol misuse in the past 3 years? (a) Is it controlled?	Yes	No
3.	Use of illegal drugs or other substances, or misuse of prescription medication in the last 6 years? (a) If Yes, the type of substance misused? (b) Is it controlled? (c) Has the applicant undertaken an opiate treatment programme?	Yes	
1	If Yes, give date started		

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6	Sleep disorders	6. Does the applicant have a history of liver disease of any origin?	Yes No
1.	Is there a history or evidence of Obstructive Yes N Sleep Apnoea Syndrome or any other medical condition causing excessive sleepiness?		
	If No, go to section 7, Other medical conditions. If Yes, please give diagnosis and answer all questions below.	<ul> <li>7. Is there a history of renal failure?</li> <li>If Yes, please give details in section 9, page 7.</li> </ul>	Yes No
	<ul> <li>a) If Obstructive Sleep Apnoea Syndrome, please indicate the severity:</li> </ul>	8. Does the applicant have severe symptomatic respiratory disease causing chronic hypoxia?	Yes No
	Mild (AHI <15)       Moderate (AHI 15 - 29)         Severe (AHI >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. DVLA does not prescribe different measurements as this is a clinical issue. Please give details in section 9 page 7, Further details         b) Please answer questions (i) to (vi) for all sleep conditions.       Yes N         (ii) Date of diagnosis:       Yes N         (iii) Is it controlled successfully?       Yes N         (iv) Is applicant compliant with treatment?       Yes N	<ul> <li>bees any medication currently taken cause the applicant side effects that could affect safe driving?</li> <li>If Yes, please fill in section 8, Medication and give symptoms in section 9, page 7.</li> <li>10. Does the applicant have any other medical condition that could affect safe driving?</li> </ul>	uding ry).
	<ul> <li>(v) Please state period of control:</li> <li>years months</li> <li>(vi) Date of last review.</li> </ul>	Medication Dosage Reason for taking:	
7	Other medical conditions	Approximate date started (if known): D D M M	YY
1.	Is there a history or evidence of narcolepsy?	No Medication Dosage	
2.	Is there currently any functional impairment Yes N that is likely to affect control of the vehicle?	No Reason for taking: Approximate date started (if known): D D M M	YY
3.	Is there a history of bronchogenic carcinoma Yes N or other malignant tumour with a significant liability to metastasise cerebrally?	No Medication Dosage	
4.	Is there any illness that may cause significant Yes N fatigue or cachexia that affects safe driving?	No Reason for taking: Approximate date started (if known): D D M M	YY
5.	If Yes, is the applicant able to communicate	No       Medication     Dosage       No	YY

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Date of birth

## 9 Further details

Please send us copies of relevant hospital notes. Do not send any notes not related to fitness to drive. Use the space below to provide any additional information.

## 10 Consultants' details

Consultant in	
Reason for attendance	
Name	
Address	
Date of last appointment:	DDMM
Consultant in	
Reason for attendance	
Name	
Address	
Date of last appointment:	DDMM
Date of last appointment: If more consultants seen give	

Date of birth

# Sections 11 and 12 to be completed by the GP/Doctor carrying out the examination 11 Additional information

Patients' weight (kg)	
Height (cms)	
Details of smoking habits, if any	
Number of alcohol units taken each week	

**12 GP / Doctor's details** (please print name and address in capital letters)

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

		Surg	ery stamp	
Full Name:	1			$\overline{}$
Address:				
Post Code:				
Telephone:				
Email address:				

I confirm that:

- 1. I am currently GMC registered and licensed to practice in the UK.
- 2. I have checked the applicant's identity.
- 3. I had full access to the applicant's medical records at the time of the medical examination.

Applicant's Full Name: \_\_\_\_\_ Date of Birth: DD/MM/YYYY

### **ID Provided:**

Signature of GP (Doctor)	
Date of examination	DD/MM/YYYY

#### 13 Applicant details

Name:	Date of Birth	DD/MM/YYYY
Address:	Tel No.	
	Mobile No.	
	Email address	
Post Code:		

#### About your GP (Doctor) / Group Practice

GP (Doctor) Group	Те	elephone:	
Address:			
	E	mail address:	
Post Code:			

#### 14 Applicant's 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 to confirm the statements below.

#### Important information about Consent

On occasion, as part of the investigation into your fitness to drive a hackney carriage/private hire vehicle, Preston City Council may require further information from your doctor, specialist, appropriate healthcare professional, optician or optometrist and/or the Councils independent Group 2 Medical Specialist. Only information relevant to the assessment of your fitness to drive will be requested.

#### CONSENT AND DECLARATION

- I authorise my doctor(s), specialist(s), appropriate healthcare professional(s), optician(s) or optometrist(s) to release reports/medical information about my condition, relevant to my fitness to drive, to Preston City Council.
- I authorise Preston City Council to disclose such reports/medical information as may be necessary to the investigation of my fitness to drive, to a doctor(s), specialist(s), other appropriate healthcare professionals(s), optician(s), optometrist(s) or occupational health professional(s), or any other name it may be known by, and the Council's Taxi and Miscellaneous Committee.
- I understand that it is a criminal offence if I make a false declaration to obtain a hackney carriage or private hire vehicle driver's licence with Preston City Council and can lead to prosecution.
- I authorise Preston City Council to inform my doctor(s), specialist(s), other appropriate healthcare profession(s), optician(s) or optometrist(s) of the outcome of my case and release reports/medical information to them.
- I declare that I have checked the details I have given on the Medical Examination Report and that, to the best of my knowledge and belief, they are correct.

Full Name of Applicant:	
Signature of Applicant:	
Date:	