Hinckley & Bosworth Borough Council 5 year validity	**DVLA GROUP 2 - Medical Examination Report** **Part 1 (Vision) to be completed by an Optician** **Parts 2 – 6 to be completed by the Doctor** • Please answer **all** questions

Please give patients weight (kg/st) _____ Height (cm/ft) _____

Please give details of smoking habits, if any _____

Please give number of alcohol units taken each week _____

Details of specialist(s) /consultants, including address	1	2	3
Speciality			
Date last seen			

Current medication including exact dosage and reason for each treatment _____

Date when first licensed to drive a hackney carriage/private hire vehicle _____

1 Vision – This Section Must Be Completed By an Optician

Please tick ✓ the appropriate box(es)	**YES**	**NO**
1. Is the visual acuity **at least** 6/7.5 (0.8 decimal) in the better eye and at least 6/60 (0.1) in the other (Corrective lenses may be worn) as measured with the full size 6m Snellen chart	☐	☐
2. Do corrective lenses have to be worn to achieve this standard?	☐	☐
If **Yes** is the:-		
(a) uncorrected acuity at least 3/60 in the right eye?	☐	☐
(b) uncorrected acuity at least 3/60 in the left eye? (3/60 being the ability to read the 6/60 line of the full size 6m Snellen chart at 3 metres)	☐	☐
(c) correction well tolerated?	☐	☐

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

Please convert any 3 metre readings to the 6 metre equivalent

Uncorrected			**Corrected (if applicable)**		
Right		Left	Right		Left

4.	Is there a defect in his/her binocular field of vision (central and/or peripheral)?	☐	☐
5.	Is there diplopia? (controlled or uncontrolled)?	☐	☐
6.	Does the applicant have any other ophthalmic condition?	☐	☐

If **YES** to4, 5 or 6 **please give details in <u>Section 7</u> and enclose any relevant visual field charts or hospital letters.**

Optician Details

Name	**Optician Stamp and Signature**
Address	
Email Address	

Applicant's Name _____ **DOB** _____

2 Nervous System

		YES	NO
1.	Has the applicant had any form of epileptic attack?	☐	☐
	(a) If **Yes** please give date of last attack ☐☐ ☐☐ ☐☐		
	(b) if treated, please give date when treatment ceased ☐☐ ☐☐ ☐☐		
2.	Is there a history of blackout or impaired consciousness within the last 5 years?	☐	☐
	If **YES** please give date(s) and details in **Section 7**		
3.	Does the applicant suffer from narcolepsy/cataplexy?	☐	☐
	If **YES** please give 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 tick the relevant box(es) and give dates and full details at **Section 7**		
	(a) Stroke/TIA *please delete as appropriate*	☐	
	(b) Sudden and disabling dizziness/vertigo within the last 1 year with the liability to recur	☐	
	(c) Subarachnoid haemorrhage	☐	
	(d) Serious head injury with the last 10 years	☐	
	(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

		YES	NO
1.	Does the applicant have diabetes mellitus?	☐	☐
	If **NO** please proceed to **Section 4**		
	If **YES** please answer the following questions		
2.	Is the diabetes managed by:-	☐	☐
	(a) Insulin?		
	If YES please give date started on insulin ☐☐☐☐ ☐☐		
	(b) Oral hypoglycaemic agents and diet?	☐	☐
	(c) Diet only?	☐	☐
3.	Does the patient test blood glucose at least twice every day?	☐	☐
4.	Is there evidence of :		
	(a) Loss of visual field?	☐	☐
	(b) Severe peripheral neuropathy, sufficient to impair limb function for safe driving?	☐	☐
	(c) Diminished/Absent awareness of hypoglycaemia?	☐	☐
5.	Has there been laser treatment for retinopathy?	☐	☐
	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?	☐	☐
	If **YES** to any of 4-6 above, please give details in **Section 7**		

Applicant's Name | **DOB**

4 Psychiatric Illness

	YES	NO
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

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

NB If applicant remains under specialist cardiac clinic(s) ensure details are completed on page 5

5A Coronary Artery Disease

	YES	NO
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

1. Myocardial Infarction? ☐ ☐

If **YES** please give date(s)

2. Coronary artery by-pass graft? ☐ ☐

If **YES** please give date(s)

3. Coronary Angioplasty (with or without stent)? ☐ ☐

If **YES** please give date(s)

4. Has the applicant suffered from Angina? ☐ ☐

If **YES** please give the ate of the last attack

Please proceed to next Section 5B

Applicant's Name _____ **DOB** _____

5B Cardiac Arrhythmia

	YES	NO
Is there a history of, or evidence of, cardiac arrhythmia?	☐	☐

If **NO** proceed to **Section 5C**

If **YES** please answer all questions below and give details at **Section 7** of the form

1.	Has the applicant had a significant documented disturbance of cardiac rhythm with the past 5 years?	☐	☐
2.	Has the arrhythmia been controlled satisfactorily for at least 3 months?	☐	☐
3.	Has a cardiac defibrillator device been implanted?	☐	☐
4.	Has a pacemaker been implanted?	☐	☐
	If **YES**:		
	(a) Has the pacemaker been implanted for at least 6 weeks?	☐	☐
	(b) Since implantation, is the patient now symptom free from this condition?	☐	☐
	(c) Does the applicant attend a pacemaker clinic regularly?	☐	☐

Please proceed to next Section 5C

5C Peripheral Arterial Disease

1.	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.				
			YES		**NO**
	PERIPHERAL ARTERIAL DISEASE		☐		☐
	AORTIC ANEURYSM, IF YES:				
	(a) Site of Aneurysm	**Thoracic**	☐	**Abdominal**	☐
	(b) Has it been repaired successfully		☐		☐
	(c) Is the transverse diameter more than 5 cm		☐		☐
	DISSECTION OF THE AORTA, IF YES:				
	(a) Has it been repaired successfully		☐		☐

Please proceed to next Section 5D

5D Valvular/Congenital Heart Disease

	YES	NO
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

1.	Is there a history of congenital heart disorder?	☐	☐
2.	is there a history of heart valve disease	☐	☐
3.	Is there any history of embolism? (**not** pulmonary embolism)	☐	☐
4.	Does the applicant currently have significant symptoms?	☐	☐
5.	Has there been any progression since the last licence application? (if relevant)	☐	☐

Please proceed to next section 5E

Applicant's Name _____ **DOB** _____

5E Cardiomyopathy

	YES	NO
Does the applicant have a history of ANY of the following conditions:	☐	☐
(a) A history of, or evidence of heart failure?		
(b) established cardiomyopathy?		
(c) a heart or heart/lung transplant?		

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 Cardiac Investigations

This section must be completed for all applicants

	YES	NO
1. Has a resting ECG been undertaken?	☐	☐
If **YES** does it show:	☐	☐
(a) pathological Q waves?	☐	☐
(b) left bundle branch block?	☐	☐
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		
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		
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		
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		
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		

Please proceed to Section 5G

5G Blood Pressure

This section must be completed for all applicants

	YES	NO
1. Is today's resting systolic pressure 180mm Hg or greater?	☐	☐
2. Is today's resting diastolic pressure 100mm Hg or greater?	☐	☐
3. Is the applicant on anti-hypertensive treatment?	☐	☐
If **YES** to any of the above, please supply today's reading ☐		

Applicant's Name | **DOB**

6 General

Please answer all questions in this section. If your answer is **YES** please give full details in **Section 7**

		YES	NO
1.	Is there **currently** a disability of the spine or limbs, likely to impair control of the vehicle?	☐	☐
2.	Is there a history of bronchogenic carcinoma or other malignant tumour, for example, malignant melanoma, with a significant liability to metastasise cerebrally?	☐	☐
	If **YES** please give dates and diagnosis and state whether there is current evidence of dissemination		
3.	Is the applicant profoundly deaf?	☐	☐
	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?	☐	☐
4.	Is there a history of either renal or hepatic failure?	☐	☐
5.	Does the applicant have sleep apnoea syndrome?	☐	☐
	If **YES** has it been controlled successfully?	☐	☐
6.	Is there any other **Medical Condition** causing excessive daytime sleepiness?	☐	☐
6a	If **YES** please give full details below		
7.	Does the applicant have severe symptomatic respiratory disease causing chronic hypoxia?	☐	☐
8.	Does any medication currently taken cause the applicant side effects which impair his/her safe driving?	☐	☐

FITNESS TO DRIVE A HACKNEY CARRIAGE / PRIVATE HIRE VEHICLE

	YES	NO
The applicant meets DVLA C1 category, group 2 medical standard of fitness and is therefore fit to drive a hackney carriage / private hire vehicle.	☐	☐

	YES	N/A
The applicant has diabetes treated by insulin and should be considered fit and granted a licence for 12 months once he has produced to you the form “Medical statement for drivers with diabetes using Insulin”, duly completed by a diabetes consultant and by himself.	☐	☐

	YES	N/A
I have found a matter of relevance but I recommend that you grant him / her renewal of their licence for the time being and that you follow the recommendations in **Section 7** regarding further medical evidence within 6 weeks.	☐	☐

Applicant's Name		**DOB**	

7 Please 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 Hinckley & Bosworth 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 at a driving assessment centre. Only information relevant to the assessment of your fitness to drive will be released. All information will be treated as confidential.

Consent and Declaration

I authorise my doctor(s) and Specialist(s) to release reports to Hinckley & Bosworth Borough Council's Principal Licensing Officer and the Licensing Committee, with regards to my fitness to drive a Hackney Carriage / Private Hire vehicle.
I authorise such relevant medical information as may be necessary to the investigation of my fitness to drive to doctors, paramedical 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.

Signature …….. Date ……

Applicant's Details

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

Please make sure that you have printed your name and date of birth on each page before sending this form with your application

9 Your Details

Your Name	
Your Address	
Email Address	

Date of Birth	
Home Telephone Number	
Work/Daytime Number	

About your GP/Group Practice

GP/Group Name
Address
Telephone
Email Address

Medical Practitioner Details - the examination must be completed by a Doctor from your Group Practice

10 Doctor's Details

Name
Address
Email Address

Surgery Stamp

Signature of Medical Practitioner …… Date ……

Notes for the examining doctor:

Taxi and private hire drivers must achieve the same medical standard as DVLA group 2 (Medical Aspects of Fitness to Drive, The Medical Commission on Accident Prevention 1995; and Fitness to Drive, A Guide for Health Professionals, Tim Carter, Chief Medical Advisor to the Department for Transport, 2006)

If the applicant is applying for a new licence, the required medical standard must be met before the person can be certified as fit. If an applicant is renewing an existing licence, and the problem which is identified is not of immediate medical concern, such as blood pressure marginally above the DVLA group 2 level or visual acuities marginally worse than the DVLA group 2 level, the candidate should be considered to be a "provisionally fit" and allowed to hold a licence with appropriate instructions to the licensing authority.

An applicant using insulin for diabetes must produce both a declaration from a diabetes consultant and a declaration signed by himself, confirming a satisfactory level of control and monitoring as specified in the accompanying form “Medical statement for drivers with diabetes using insulin". He should not be considered fit to hold a licence until this is done.

An applicant taking sulphonylureas or glinides must produce both a declaration from a doctor and from himself confirming a satisfactory level of control and monitoring as specified in the accompanying form "Medical statement for drivers with tablets controlled diabetes" (position statement) but may be allowed a period of grace to obtain this evidence.

A person who has a history of established ischaemic heart disease including a heart attack, angina, or insertion of a stent at any time in the past, whether recent or distant, must have three yearly exercise treadmill tests or another equivalent functional test and be able to demonstrate a satisfactory standard equivalent to DVLA group 2 standard.