MEDICAL EXAMINATION REPORT

Information and useful notes

Table of Contents

A. What you have to do 2
B. Information for the doctor 3
C. Medical Standards 4
1. Epilepsy or liability to epileptic attacks 4
1a. First epileptic attack or solitary seizure 4
2. Diabetes 4
3. Eyesight 5
4. Other medical conditions 5
5. Excessive sleepiness or Sleep Apnoea 6
Medical Examination Report 8

Important Information

You must get the medical report filled in if:

- This is your first application
- If you are renewing your licence and you are age 45 or over. From the age of 45 a medical report will be required every 5 years until you are 65. From age 65 onwards you will need a medical report every year.

Instructions for you and your doctor are detailed on the next 2 pages.

A. What you have to do

1. You must arrange an appointment for a full medical examination with a doctor registered or practising in the United Kingdom. The medical examination includes a vision assessment which some doctors will not be able to complete. If your doctor is unable to fully answer all the questions on the vision assessment you must have it filled in by an optician or optometrist.

   You must read section C pages 4-8 before arranging an appointment to find out if you can meet Group 2 medical standard.

2. You must make sure that the doctor has access to your medical history. There is a form for your registered GP to complete at section 14 to confirm they have provided this. Your medical history may be in the form of a medical summary. It may be provided to the doctor electronically or in paper form.

3. If, after reading the notes, you have any doubts about your fitness to meet the medical standards ask a doctor/optician for advice before getting them to fill in the form. If you do not do this we may not issue you with a licence. The doctor will normally charge you for filling in the form and those registered for VAT charge VAT on top of their fee. The report must be completed at your expense.

4. Fill in section 10 and section 11 of the medical report when you are with the doctor carrying out the medical examination.

5. If you develop a condition which could affect your ability to drive safely (see pages 4-8) and you hold, or are applying for a licence, you must inform the licensing authority immediately.

6. You must check all sections of the medical report have been filled in fully before submitting your medical/application. Incomplete medicals will be returned which will delay your application.

7. You may be required to undergo a further medical examination or additional tests at your expense to prove your fitness to drive. Please note that in the case of new applications they will not be granted until your fitness to drive has been ascertained. In the case of renewals, or during the currency of a licence should a medical condition develop, your licence may be suspended, or not renewed pending the outcome of a further examination and/or test.

B. Information for the doctor

1. You must have access to and have had regard to the patients' medical record when completing the report. The medical practice where the patient is registered must confirm they have provided this as detailed on the last page of this report. The medical history may be in the form of a medical summary. It may be provided to you electronically or in paper form.

2. Please fully examine the patient.

3. Fill in sections 1-10 of the medical report. You may find it helpful to read DVLA's "Assessing Fitness to Drive" guidance. You can download this from the gov.uk website at https://www.gov.uk/government/publications/assessing-fitness-to-drive-a-guide-for-medical-professionals

4. Only complete the vision assessment if you are able to fully and accurately complete all the questions. If you are unable to do this you must tell the applicant to have this part of the assessment completed by an optician or optometrist.

   If glasses are worn to meet the current eyesight standard for driving, the patient must bring their current prescription to the examination. The eyesight examination must be undertaken using the prescription currently worn for driving.

   You must be able to:
   - confirm the strength of glasses (dioptres) from a prescription
   - measure the applicant's visual acuity to at least 6/7.5 (decimal 0.8) of a Snellen chart

   We cannot accept a Snellen reading shown with a plus (+) or minus (-) e.g. 6/6-2 or 6/9+3.

4. Make sure you fill in all sections, including consultant/specialist details on the front of the form and the surgery/practice stamp or GMC registration number in Section 10.

5. You must highlight the appropriate line at Section 10 stating whether the patient meets, or does not meet the group 2 criteria.

C. Medical Standards

Medical standards for Private Hire and Hackney Carriage drivers are higher than those for regular car drivers. All applicants must meet the DVLA Group 2 Entitlement of fitness to drive.

If you have any of the following medical conditions you will not be able to obtain, or retain a Private Hire or Hackney Carriage driver licence.

1. Epilepsy or liability to epileptic attacks

If you have been diagnosed as epileptic or have had a spontaneous epileptic attack(s) which includes all events major, minor and auras, you will need to be free of further epileptic attack without taking anti-epilepsy medication for 10 years. If you have a condition that causes an increased liability to seizures for example serious head injury, the risk of you having a seizure must fall to no greater than 2% per annum. If these conditions are not met then your application will be refused or your licence revoked.

1a. First epileptic attack or solitary seizure

If you have had an isolated seizure, you may be entitled to drive after 5 years from the date of the seizure provided that after 5 years, a neurologist has made a recent assessment and clinical factors or investigation results (for example, EEG or brain scan) indicate no annual risk greater than 2% of a further seizure.

Such licensing also requires that there has been no need for epilepsy medication throughout the 5 years up to the date of the application.

You are strongly advised to discuss your eligibility to meet the Group 2 Standard of fitness to drive with your doctor(s) before applying for a licence.

2. Diabetes

If you have insulin-treated diabetes you may obtain a licence as long as you can meet the strict criteria for controlling and monitoring diabetes. This includes:

- No episode of severe hypoglycaemia has occurred in the preceding 12 months.
- Has full awareness of hypoglycaemia.
- Regularly monitors blood glucose at least twice daily and at times relevant to driving using a glucose meter with a memory function to measure and record blood glucose levels. At the annual examination by an independent Consultant specialist in diabetes. At the examination the consultant will require sight of glucose self monitoring records for the previous 4 weeks stored on the memory of a glucose meter.
- Must demonstrate an understanding of the risks of hypoglycaemia.
- There are no other debarring complications of diabetes such as a visual field defect.

3. Eyesight

All new applicants must have:

- A visual acuity of at least 6/7.5 (0.8 decimal) in the better eye;
- A visual acuity of at least 6/60 (0.1 decimal) in the other eye; and
- Where glasses are worn to meet the minimum standards, they should have a corrective power ≤ +8 dioptres in any meridian of either lens.

Normal binocular field

All applicants must have a normal binocular field of vision. This means that any area of defect in a single eye is totally compensated for by the field of the other eye.

Various grandfather rights may apply to existing licence holders. Please contact the Licensing Team for further information.

4. Other medical conditions

If there is established coronary heart disease an exercise tolerance test or other stress test will be required at intervals not to exceed 3 years. After Acute Coronary Syndrome an LV ejection fraction of greater than 40% is required.

Any person who cannot meet the recommended medical guidelines for the following conditions is likely to have their application refused or licence revoked:

- Within 3 months of a coronary artery bypass graft (CABG).
- Angina, heart failure or cardiac arrhythmia which remains uncontrolled.
- Implanted cardiac defibrillator.
- Hypertension where the blood pressure is persistently 180 systolic or more or 100 diastolic or more.
- A stroke or Transient Ischaemic Attack (TIA) within the last 12 months.
- Unexplained loss of consciousness with liability to recurrence.
- Meniere's Disease, or any other sudden and disabling vertigo within the past 1 year, with a liability to recurrence.
- Difficulty in communicating by telephone in an emergency.
- Major brain surgery and/or recent severe head injury with serious continuing after effects.
- Parkinson's disease, multiple sclerosis, or other chronic neurological disorders with symptoms likely to affect safe driving.
- Psychotic illness in the past 12 months.
- Serious psychiatric illness.
- If major psychotropic or neuroleptic medication is being taken.
- Dementia.

- Cognitive impairment likely to affect safe driving.
- Alcohol and/or drug misuse in the past 1 year (specified drugs only) or alcohol and/or drug dependency in the past 3 years. Additional restrictions may be required for high risk offenders as set out in the DVLA guidance.
- Any malignant condition in the last 2 years, with a significant liability to metastasise (spread) to the brain. Any person who has had a malignant brain tumor is unlikely to meet the medical standard.
- Any other serious medical condition likely to affect the safe driving of a medium/large goods or passenger carrying vehicle.
- Cancer of the lung

5. Excessive sleepiness or Sleep Apnoea

Facts you should know about excessive sleepiness/tiredness and driving

There is no excuse for falling asleep at the wheel and it is not an excuse in law.

- Up to one fifth of accidents on motorways and other monotonous types of roads may be caused by drivers falling asleep at the wheel.
- 18-30 year old males are more likely to fall asleep at the wheel when driving late at night.
- Modern life styles such as early morning starts, shift work, late and night socialising, often lead to excessive tiredness by interfering with adequate rest.
- Drivers who fall asleep at the wheel have a degree of warning.
- Natural sleepiness/tiredness occurs after eating a large meal.
- Changes in body rhythm produce a natural increased tendency to sleep at two parts of the day:

  Midnight - 6am
  2pm - 4pm
- Although no one should drink and drive at any time, alcohol consumed in the afternoon may be twice as potent in terms of producing sleepiness and driving impairment as the same amount taken in the evening.
- Prescribed or over-the-counter medication can cause sleepiness as a side effect. Always check the label, if you intend to drive.

Medical conditions causing sleepiness

All drivers are subject to the pressures of modern life, but many drivers are unaware that some medical conditions also cause excessive sleepiness/tiredness. These, alone or in combination with the factors mentioned previously, may be sufficient to make driving unsafe. A road traffic accident may be the first clear indication of such a sleep disorder.

If you know you have uncontrolled sleepiness you MUST not drive.

Obstructive Sleep Apnoea (OSA) and Obstructive Sleep Apnoea Syndrome (OSAS)

Sleep Apnoea is a condition which often goes undiagnosed. If it is not fully assessed and treated, this can cause sleepiness and other symptoms which can be a serious risk factor in road traffic accidents.

- Sleep apnoea is often accompanied by tiredness.
- Sleep apnoea is the most common sleep related medical disorder.
- Sleep apnoea significantly increases the risk of traffic accidents.
- Sleep apnoea occurs most commonly, but not exclusively, in overweight individuals.
- Partners often complain about snoring and notice that the sufferers have breathing pauses during sleep.
- Sleep apnoea sufferers rarely wake from sleep feeling fully refreshed and tend to fall asleep easily when relaxing.
- Long distance lorry and bus drivers affected by sleep apnoea are of great concern as most will be driving on monotonous roads/motorways and the size or nature of the vehicle gives little room for error.
- Estimates suggest at least four in every 100 men have sleep apnoea. Sleep problems arise more commonly in older people.
- Lifestyle changes such as weight loss or cutting back on alcohol, will help ease the symptoms of sleep apnoea.
- The most widely effective treatment for sleep apnoea is continuous positive airway pressure (CPAP). This requires the patient to wear a soft face mask during sleep to regulate breathing. This treatment enables patients to have a good night's sleep, so reducing sleepiness during normal waking hours and improving concentration.

Other sleep related conditions

Illnesses of the nervous system, such as **Parkinson's Disease, Multiple Sclerosis** (MS)**, Motor Neurone Disease** (MND) and **Narcolepsy** may also cause excessive sleepiness or fatigue although sometimes these illnesses alone may cause drivers to be unfit for driving.

Tiredness or excessive sleepiness can be a non-specific symptom of Parkinson's disease, MS, MND, or may also be related to prescribed medication.

Narcolepsy also causes daytime sleepiness/tiredness as well as other symptoms that may be disabling for drivers.

Medical Examination Report

To be filled in by the Doctor. The Patient must fill in sections 11, 12 and 13 in the doctor's presence (please use black ink)

Patients weight (kg) _____ Height (cms) _____

Details of smoking habits, if any _____

Number of alcohol units taken each week _____

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

1	2	3

Date of last appointment D D M M Y Y D D M M Y Y D D M M Y Y

List of medications

Medication	Dosage	Reason Taken

1 Vision

Please tick ✓ the appropriate box(es) **YES** **NO**

1. Please confirm the scale you are using to express the applicant's visual acuities
   Snellen ☐ Snellen expressed as a decimal ☐ LogMAR ☐

2. Is the visual acuity **at least** 6/7.5 in the better eye and at least 6/60 in the other? ☐ ☐
(corrective lenses may be worn) as measured with the full size 6m Snellen chart

   (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 standard is not met the applicant may need further assessment. Right _____ Left _____

   (b) Are corrective lenses worn for driving? If no go to Q2 ☐ ☐

   (c) 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.

   Right _____ Left _____

   (d) What kind of corrective lenses are worn to meet this standard?
   Glasses ☐ Contact Lenses ☐ Both together ☐

   (e) If glasses are worn for driving is the corrective power greater than plus (+) 8 dioptres in any meridian of either lens? ☐ ☐

   (f) If correction is worn for driving is it well tolerated? If no please give full details in Section 9 ☐ ☐

3. Is there a known visual field defect? ☐ ☐

Patient's Name: _____ **Date of Birth:** _____

4. Is there a history of any medical condition that might results in a visual field defect? ☐ ☐

   (a) If yes give has a visual field defect been excluded? ☐ ☐
   (b) Please provide the condition

If formal visual field testing is considered necessary we will ask for this at a later date

5. Is there diplopia? ☐ ☐
   (a) Is it controlled? ☐ ☐
   Please indicate below and give full details in Question 7
   Patch or glasses with frosted glass ☐ Glasses with/without prism ☐ Other (provide details in S9) ☐

6. Does the applicant on report symptoms of any of the following that impairs their ability to drive? ☐ ☐

   Please indicate below and give full details in Section 9.
   (a) Intolerance to glare (causing incapacity rather than discomfort) and/or ☐ ☐
   (b) Impaired contrast sensitivity and/or ☐ ☐
   (c) Impaired twilight vision ☐ ☐

7. Does the patient have any other ophthalmic condition affecting their visual acuity or visual field? ☐ ☐

   If **YES** to any of questions 2 to 5 please give details in **Question 7** and enclose any relevant visual field charts or hospital letters.

8. Details or additional information

Name of examining doctor or optician undertaking	
I confirm that this report was filled in by me at examination and the applicant's history has been taken into consideration.	
Signature	
Date of Signature	
GOC or GMC number	
Doctor, optometrist or optician's stamp	

Patient's Name: **Date of Birth:**

2 Neurological Disorders

	YES	NO
Is there a history of or evidence of any neurological disorder (see conditions in questions 1 to 11 below)? If **NO** go to **Section 3.** If **YES** please answer the following questions.	☐	☐
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 D D M M Y Y Last episode D D M M Y Y		
(c) Is the patient currently on anti seizure medication? If **YES**, please fill in current medication on the appropriate section on the front of this form	☐	☐
(d) If no longer treated when did the treatment end? D D M M Y Y		
(e) Has the patient had a brain scan? If **YES**, please give details in Section 9 and supply reports where available.	☐	☐
2. Has the applicant experienced any dissociative/functional seizures?	☐	☐
(a) If yes please give date of most recent episode D D M M Y Y		
(b) If yes have any of these episode(s) occurred, or are they considered likely to occur, whilst driving?	☐	☐
3. Stroke or TIA	☐	☐
If yes please give dates: D D M M Y Y		
(a) Has there been a **full** recovery	☐	☐
(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/vertigo within the last year with a liability to recur?	☐	☐
5. Subarachnoid haemorrhage (non-traumatic)?	☐	☐
6. Serious head injury within the last 10 years?	☐	☐
7. Any form of brain tumour?	☐	☐
8. Other intracranial pathology?	☐	☐
9. Chronic neurological disorders	☐	☐
10. Parkinson's disease?	☐	☐
11. Blackout, impaired consciousness or loss of awareness within the last 5 years?	☐	☐

3 Diabetes Mellitus

	YES	NO
Does the patient have diabetes mellitus? If **NO**, please go to **Section 4** If **YES**, please answer the following questions:	☐	☐
1. Is the diabetes managed by:		
(a) Insulin? If **NO** go to 1c If **YES**, please give date started on insulin D D M M Y Y	☐	☐
(b) Are there at least 4 continuous weeks of blood glucose readings stored on a memory meter(s)? If no please give details in Section 9.	☐	☐
(c) Other injectable treatments?	☐	☐
(d) A Sulphonylurea or a Glinide?	☐	☐
(e) Oral hypoglycaemic agents and diet? If **YES** to (a) to (e), please fill in current medication on the appropriate section on the front of this form	☐	☐
(f) Diet only?	☐	☐

Patient's Name: _____ **Date of Birth:** _____

2.
(a) Does the patient test blood glucose at least twice every day? ☐ ☐
(b) Does the patient test at times relevant to driving? (within 2 hours of starting their the first journey of the day and continuing to check at least every 2 hours during their journey. There must be no more than 2 hours between glucose checks at any time during their journey) ☐ ☐
(c) Does the patient keep fast acting carbohydrate within easy reach when driving? ☐ ☐
(d) Does the patient have a clear understanding of diabetes and the necessary precautions for safe driving? ☐ ☐

3. (a) Has the applicant ever had a hypoglycaemic episode? ☐ ☐
(b) If YES, is there full awareness of hypoglycaemia? ☐ ☐

4. Is there a history of hypoglycaemia in the last 12 months requiring assistance of another person? ☐ ☐
If yes please give details and dates below

5. Has there been laser treatment or intra-vitreal treatment for retinopathy? ☐ ☐
If **YES**, please give date(s) of most recent treatment D D M M Y Y

4 Cardiac

	YES	NO
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 9** of the form and enclose relevant hospital notes

4A Coronary Artery Disease

	YES	NO
1. Has the patient ever had an episode of angina?	☐	☐
If **YES**, please give date of the last known attack D D M M Y Y		
2. Acute coronary syndrome including myocardial infarction?	☐	☐
If **YES**, please give date(s) D D M M Y Y		
3. Coronary angioplasty (P.C.I)?	☐	☐
If **YES**, please give date of most recent intervention D D M M Y Y		
4. Coronary artery by-pass graft surgery?	☐	☐
If **YES**, please give date(s) D D M M Y Y		
5. If yes to any of the above are there any physical health problems or disabilities (eg mobility, arthritis or COPD) that would make the applicant unable to undertake 9 minutes of the standard Bruce Protocol ETT? If yes please give details below	☐	☐

4B Cardiac Arrhythmia

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

If **NO**, please go to **Section 4C**
If **YES** please answer all questions below, give details in **Section 9** of the form and enclose relevant hospital notes.

1. Has there been a significant disturbance of cardiac rhythm causing/likely to cause incapacity in the last 5 years? ☐ ☐
2. Has the arrhythmia been controlled satisfactorily for at least 3 months? ☐ ☐

Patient's Name: **Date of Birth:**

3. Has an ICD (Implanted Cardiac Defibrillator) or biventricular pacemaker with defibrillator/cardiac resynchronisation therapy pacemaker (CRT-D type) been implanted? ☐ ☐

4. Has a pacemaker or biventricular pacemaker/cardiac resynchronisation therapy pacemaker (CRT-P type) been implanted? ☐ ☐

If **YES**

(a) Please provide date of implantation D D M M Y Y

(b) Is the patient free of the symptoms that caused the device to be fitted? ☐ ☐

(c) Does the patient 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, peripheral arterial disease (excluding Buerger's disease), aortic aneurysm or dissection? ☐ ☐

If **NO**, please go to **Section 4D**

If **YES** please answer all relevant boxes below, and give details in **Section 9** of the form.

1. Peripheral arterial disease (excluding Buerger's Disease) ☐ ☐

2. Does the patient have claudication? ☐ ☐

If **YES** would the applicant be able to undertake 9 minutes of the standard Bruce Protocol ETT? ☐ ☐

3. Aortic aneurysm ☐ ☐

If **YES:**

(a) Site of Aneurysm: **Thoracic** ☐ **Abdominal** ☐

(b) Has it been repaired successfully? ☐ ☐

(c) Please provide latest transverse aortic diameter measurement and date obtained using measurement and date boxes.

. cm D D M M Y Y

4.

(a) Dissection of the aorta? ☐ ☐

(b) If yes, has the dissection been successfully repaired? ☐ ☐

If **YES** please provide copies of all reports including those dealing with any surgical treatment.

5. Is there a history of Marfan's disease? ☐ ☐

(a) If yes, are there any associated risk factors? ☐ ☐

*risk factors include

- family history of aortic dissection
- greater than 3mm per year increase than aneurysm diameter
- pregnancy

4D Valvular/Congenital Heart Disease

YES **NO**

Is there a history of, or evidence of, valvular or congenital heart disease? ☐ ☐

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

If **YES** please answer all questions below and give details in **Section 9** of the form.

1. Is there a history of congenital heart disease? ☐ ☐

2. Is there a history of heart valve disease? ☐ ☐

(a) If yes, are they symptomatic ☐ ☐

3. Is there a history of aortic stenosis? ☐ ☐

If yes please provide relevant reports including echocardiogram

4. Has there been any progression (either clinically or on scans etc) since the last licence application? ☐ ☐

Patient's Name: **Date of Birth:**

4E Cardiac Other

	YES	NO
Is there a history or evidence of heart failure?	☐	☐

If **NO** go to **Section 4F Cardiac channelopathies**

If **YES** please answer all questions below and give details in **Section 9** of the form.

1. Please provide the NYHA class, if known

2. Established cardiomyopathy? ☐ ☐
   If yes please give details in Section 9

3. Has a left ventricular assist device (LVAD) or other cardiac assist device implanted? ☐ ☐

4. A heart or lung transplant? ☐ ☐

5. Evidence or history of pulmonary arterial hypertension? ☐ ☐

4F Cardiac channelopathies

Is there a history or evidence of the following conditions? ☐ ☐

If no, go to section 4g, Blood pressure

1. Brugada syndrome? ☐ ☐

2. Long QT syndrome ☐ ☐
   If yes to either please give details in Section 9 and enclose relevant hospital notes.

4G Blood Pressure

This section must be filled in for all patients

If resting blood pressure is 180mm/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 below

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

2. Is the patient on anti-hypertensive treatment? ☐ ☐
   If YES please provide three previous readings with dates, if available

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

4H Cardiac Investigations

	YES	NO
Have any cardiac investigations been undertaken or planned?	☐	☐

If **NO** go to **Section 5**

If **YES** please answer all questions below and give details in **Section 9** of the form.

1. Is there a history of the following?
   (a) left bundle branch block (LBBB)? ☐ ☐
   (b) right bundle branch block (RBBB)? ☐ ☐

   (c) Paced rhythm? ☐ ☐
   If yes to (a),(b), or (c) please give details in section 9

Note: If Yes to questions 2 to 5 please give dates in the boxes provided, details in section 9

2. Has an exercise ECG been undertaken (or planned)? ☐ ☐
   If **YES**, please give date D D M M Y Y

3. Has an echocardiogram been undertaken (or planned)? ☐ ☐
   (a) If **YES**, please give date D D M M Y Y
   (b) If undertaken, is/was the left ejection fraction greater than or equal to 40%? ☐ ☐

4. Has a coronary angiogram been undertaken (or planned)? ☐ ☐
   If **YES**, please give date D D M M Y Y

5. Has a myocardial perfusion scan, stress echo, study or cardiac MRI been undertaken (or planned)? ☐ ☐
   If **YES**, please give date D D M M Y Y

5 Psychiatric Illness

	YES	NO
Is there any significant mental illness or cognitive impairment likely to affect safe driving?	☐	☐

If **NO**, please go to **Section 6 Substance misuse**
If **YES** please answer all questions below.

1. Significant psychiatric disorder within the past 6 months ☐ ☐
   If yes please confirm condition
2. Psychosis or hypomania/mania within the past 12 months, including psychotic depression? ☐ ☐
3. (a) Dementia or cognitive impairment? ☐ ☐
   (b) Are there concerns which have resulted in ongoing investigations for such possible diagnoses? ☐ ☐

6 Substance misuse

	YES	NO
Is there a history of drug/alcohol misuse or dependence?	☐	☐

If **NO**, please go to **Section 7 Sleep disorders**
If **YES** please answer all questions below

1. Is there a history of alcohol use disorder (sufficient to cause significant physical, mental or social consequences) in the past 10 years? ☐ ☐
2. Is there a history of an alcohol use disorder, has this been associated with any of the following features which indicate a physiological dependence on alcohol:
   (a) Required medical assistance withdrawal? ☐ ☐
   Date treatment Ended:
   D D M M Y Y
   (b) Alcohol withdrawal seizure?
   ☐ ☐
   Date treatment Ended:
   D D M M Y Y

Patient's Name: **Date of Birth:**

3. Based on their clinical record and/or account of drinking provided to you, is their alcohol consumption:

(a) Abstinent? Yes ☐ No ☐ Don't know
If yes, for how long

(b) Controlled? Yes ☐ No ☐ Don't know

4. Use of illegal drugs or other substances, or misuse of prescription medication in the past 6 years? **YES** ☐ **NO** ☐

(a) If yes, the type of substance misused?

(b) Is it controlled? ☐ ☐
(c) Has the applicant undertaken an opiate treatment programme? ☐ ☐

If yes, give date started D D M M Y Y

7 Sleep disorders

1. Is there a history or evidence of Obstructive Sleep Apnoea Syndrome or any other medical condition causing excessive sleepiness? ☐ ☐

If **NO**, please go to **Section 8**
If **YES** please give diagnosis, answer all questions below and give details in **Section 9** of the form.

(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. DVLA does not prescribe different measurements as this is a clinical issue. Please give details in section 9, further details.

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

i. Date of diagnosis D D M M Y Y

ii. Is it controlled successfully? ☐ ☐
iii. Is applicant compliant with treatment? ☐ ☐

iv. Date of last review D D M M Y Y

8 Other medical conditions

Please answer all questions in this section. If your answer is 'YES' to any of the questions, please give full details in **Section 9.**

		YES	NO
1.	Is the applicant currently prescribed any of the following medication:		
	(a) Ant-seizure	☐	☐
	(b) Clozapine	☐	☐
	(c) Sulphonylurea or a Glinide?	☐	☐
	(d) Insulin	☐	☐

Patient's Name: **Date of Birth:**

9	**Further details** **PLEASE DO NOT send any notes not related to fitness to drive.** **Use the space below to provide any additional information**

Patient's Name: **Date of Birth:**

Medical Practitioner Details

To be filled in by Doctor carrying out the examination

10 Doctor and Practice Details

Name
Address
Email address
Fax number

GMC registration number or practice stamp

Declaration:

PLEASE ENSURE THIS SECTION IS COMPLETED

I certify that having had regard to the DVLA's "Assessing fitness to drive: A guide for medical professionals" I have examined the applicant and confirm he/she in my opinion:

MEETS the Group 2 entitlement of fitness to drive*

DOES NOT meet the Group 2 entitlement of fitness to drive*

(*Please delete as necessary)

	YES	NO
If the applicant is under 45 years of age do you consider a further examination necessary before the applicant reaches 45 years of age; or	☐	☐
If the applicant is over 45 do you consider a further medical examination necessary before 5 years time?	☐	☐

If YES to either statement in what period of time do you consider a further examination necessary	

2. I have checked the applicant's photo identification and confirm that the applicants name is the same as that on his/her identification and his/her appearance is the same as that on his/her photograph. As such I assume he/she is the person on the photograph

3. I confirm that I have had access to the patient's full medical history and notes when completing this medical.

Signature of Medical Practitioner:	
Date of Examination:	

Patient's Name: _____ **Date of Birth:** _____

Patient's Details

To be filled in by the patient in the presence of the Medical Practitioner carrying out the examination

11 Registered Medical Practice (if different from the examining doctor's details)

GPs Name
Practice Address
Email address

12 Your Details

Your full name
Your address

Date of Birth D D M M Y Y

Phone number

Email address

13 Patient's consent and declaration

You must sign this declaration when you are with the doctor who is completing this report.

I authorise my Doctor(s) and Specialist(s) to release report/medical information about my condition, relevant to my fitness to drive, to Bristol City Council in conjunction with my application and during the period that a licence (if granted) is in force.

I authorise Bristol City Council to disclose such relevant information as may be necessary to the investigation of my fitness to drive in conjunction with my application and during the period that a licence (if granted) is in force to doctors, paramedical staff, and to inform my doctor(s) of the outcome of the case where appropriate.

I understand that Bristol City Council may require me to undergo further medical tests at my expense now or at any point in the future, if a licence is granted, in order to establish my fitness to drive.

I declare that I have checked the details I have given on the report and that, to the best of my knowledge and belief, they are correct.

Signature of Applicant:	
Date:	

14 Declaration of registered medical practice

If the registered GP has not completed this medical, the practice where the applicant is registered must provide confirmation that the doctor completing the medical has had full access to the applicant's medical history and notes. A medical summary, either in electronic form or paper form, is acceptable.

This section should be completed by a representative of the applicants registered medical practice.

GPs Name
Practice Address
Email address

Name of person completing declaration
Position at medical practice

Name of patient

Name of doctor or practice completing medical report

I confirm that the full medical history and relevant notes held by this practice in relation to the patient named above has been provided to the doctor or medical practice named above.

Signature of medical practice representative:	
Date:	