



MEDICAL EXAMINATION REPORT

Information and useful notes

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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. 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.
3. Fill in section 9 and section 10 of the medical report when you are with the doctor carrying out the medical examination.
4. 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.
5. 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.
6. 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.
2. Please fully examine the patient and include urine screening for glucose.
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 (dioptries) 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 Diabetologist, 3 months of blood glucose readings must be available. Flash GM and RT-CGM interstitial fluid glucose monitoring systems are not permitted for the purposes of licensing. Drivers who use these devices must continue to monitor finger prick capillary blood glucose levels.
- 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 $\leq +8$ dioptries 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 9 and 10 in the doctor's presence (please use black ink)
Before filling in this form, please read the attached 'Medical Examination Report - Information and useful notes' booklet
Section B (page 5)

Patients weight (kg)

Height (cms)

Details of smoking habits, if any

Number of alcohol units taken each week

Is the urine analysis positive for Glucose? Yes No (please tick ✓ appropriate box)

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

1	2	3
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Date of last appointment

Medication	Dosage	Reason Taken
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

1

Vision

(please see Eyesight notes on page 7 of the attached 'Medical Examination Report - Information and useful notes' booklet)

Please tick ✓ the appropriate box(es)

YES NO

1. 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 Right Left

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

If Yes, please provide the visual acuities using the correction worn for driving

Right Left

- (c) 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 Section 9

2. Is there a history of any medical condition that may affect the applicant's binocular field of vision (central or peripheral)? If yes give full details at Section 9

3. Is there diplopia?

- (a) Is it controlled?

Please indicate below and give full details in Section 9

Patch or glasses with frosted glass Glasses with/without prism Other (provide details in S9)

Patient's Name:

Date of Birth:

4. Does the applicant on questioning 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

5. Does the patient have any other ophthalmic condition?
- If **YES** to any of questions 2 to 5 please give details in **Section 9** and enclose any relevant visual field charts or hospital letters.

Name of examining doctor or optician undertaking	
Signature	
Date of Signature	
GOC or GMC number	

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. | <input type="checkbox"/> | <input type="checkbox"/> |
| 1. Has the applicant had any form of seizure? | <input type="checkbox"/> | <input type="checkbox"/> |
| (a) Has the applicant had more than one attack? | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) If yes, please give date of first and last attack
First attack <input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> Last attack <input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> | | |
| (c) Is the patient currently on anti-epileptic medication?
If YES , please fill in current medication on the appropriate section on the front of this form | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) If no longer treated when did the treatment end?
<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> | | |
| (e) Has the patient had a brain scan? If YES , please give details in Section 9 and supply reports where available. | <input type="checkbox"/> | <input type="checkbox"/> |
| (f) Has the patient had an EEG? If YES , please give details in Section 9 and supply reports where available | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Has the applicant had an episode(s) of non-epileptic attack disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| (a) If yes please give date of most recent episode
<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> | | |
| (b) If yes have any of these episode(s) occurred, or are they considered likely to occur, whilst driving? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Stroke or TIA
If yes please give dates:
<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (a) Has there been a full recovery | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Has a carotid ultra sound been taken? | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) If yes was the carotid artery stenosis >50% in either carotid artery? | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) Is there a history of multiple strokes/TIAs? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Sudden and disabling dizziness/vertigo within the last 1 year with a liability to recur? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Subarachnoid haemorrhage? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Serious traumatic brain injury within the last 10 years? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Any form of brain tumour? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Other brain surgery or abnormality? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Chronic neurological disorders | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Parkinson's disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Blackout or impaired consciousness within the last 10 years? | <input type="checkbox"/> | <input type="checkbox"/> |

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

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:	<input type="checkbox"/>	<input type="checkbox"/>
1. Is the diabetes managed by:		
(a) Insulin? If YES , please give date started on insulin	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="text" value="D D"/>	<input type="text" value="M M"/>
	<input type="text" value="Y Y"/>	
(b) Are there at least 3 months of blood glucose readings stored on a memory meter(s)? If no please give details in Section 9.	<input type="checkbox"/>	<input type="checkbox"/>
(c) Other injectable treatments?	<input type="checkbox"/>	<input type="checkbox"/>
(d) A sulphonylurea or a Glinide?	<input type="checkbox"/>	<input type="checkbox"/>
(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	<input type="checkbox"/>	<input type="checkbox"/>
(f) Diet only?	<input type="checkbox"/>	<input type="checkbox"/>
2.		
(a) Does the patient test blood glucose at least twice every day?	<input type="checkbox"/>	<input type="checkbox"/>
(b) Does the patient test at times relevant to driving?(no more than 2 hours before the start of the first journey and every 2 hours whilst driving)	<input type="checkbox"/>	<input type="checkbox"/>
(c) Does the patient keep fast acting carbohydrate within easy reach when driving?	<input type="checkbox"/>	<input type="checkbox"/>
(d) Does the patient have a clear understanding of diabetes and the necessary precautions for safe driving?	<input type="checkbox"/>	<input type="checkbox"/>
3. (a) Has the applicant ever had a hypoglycaemic episode? (b) If YES , is there full awareness of hypoglycaemia?	<input type="checkbox"/>	<input type="checkbox"/>
4. Is there a history of hypoglycaemia in the last 12 months requiring assistance of another person? If yes please give details in Section 9.	<input type="checkbox"/>	<input type="checkbox"/>
5. Is there evidence of:		
(a) Loss of visual field?	<input type="checkbox"/>	<input type="checkbox"/>
(b) Severe peripheral neuropathy, sufficient to impair limb function for safe driving? If yes please give details in Section 9.	<input type="checkbox"/>	<input type="checkbox"/>
6. Has there been laser treatment or intra-vitreous treatment for retinopathy? If YES , please give date(s) of most recent treatment	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="text" value="D D"/>	<input type="text" value="M M"/>
	<input type="text" value="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	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="text" value="D D"/>	<input type="text" value="M M"/>
	<input type="text" value="Y Y"/>	
2. Acute Coronary Syndromes including Myocardial Infarction? If YES , please give date(s)	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="text" value="D D"/>	<input type="text" value="M M"/>
	<input type="text" value="Y Y"/>	
3. Coronary Angioplasty (P.C.I)? If YES , please give date of most recent intervention	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="text" value="D D"/>	<input type="text" value="M M"/>
	<input type="text" value="Y Y"/>	
4. Coronary artery by-pass graft surgery? If YES , please give date(s)	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="text" value="D D"/>	<input type="text" value="M M"/>
	<input type="text" value="Y Y"/>	

Patient's Name:

Date of Birth:

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 in Section 9.

4B Cardiac Arrhythmia

	YES	NO
Is there a history of, or evidence of, cardiac arrhythmia?	<input type="checkbox"/>	<input type="checkbox"/>
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? (eg sinoatrial disease, significant atrio-ventricular conduction defect, atrial flutter or fibrillation, narrow or broad complex tachycardia) in the last 5 years	<input type="checkbox"/>	<input type="checkbox"/>
2. Has the arrhythmia been controlled satisfactorily for at least 3 months?	<input type="checkbox"/>	<input type="checkbox"/>
3. Has an ICD (Implanted Cardiac Defibrillator) or biventricular pacemaker with defibrillator/cardiac resynchronisation therapy defibrillator (CRT-D type) been implanted?	<input type="checkbox"/>	<input type="checkbox"/>
4. Has a pacemaker or biventricular pacemaker/cardiac resynchronisation therapy pacemaker (CRT-P type) been implanted?	<input type="checkbox"/>	<input type="checkbox"/>
If YES		
(a) Please provide date of implantation	<input type="text" value="D"/>	<input type="text" value="D"/>
	<input type="text" value="M"/>	<input type="text" value="M"/>
	<input type="text" value="Y"/>	<input type="text" value="Y"/>
(b) Is the patient free of the symptoms that caused the device to be fitted?	<input type="checkbox"/>	<input type="checkbox"/>
(c) Does the patient attend a pacemaker clinic regularly?	<input type="checkbox"/>	<input type="checkbox"/>

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?	<input type="checkbox"/>	<input type="checkbox"/>
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)	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the patient have claudication?	<input type="checkbox"/>	<input type="checkbox"/>
If YES would the applicant be able to undertake 9 minutes of the standard Bruce Protocol ETT?	<input type="checkbox"/>	<input type="checkbox"/>
3. Aortic aneurysm	<input type="checkbox"/>	<input type="checkbox"/>
If YES :		
(a) Site of Aneurysm: Thoracic <input type="checkbox"/> Abdominal <input type="checkbox"/>		
(b) Has it been repaired successfully?	<input type="checkbox"/>	<input type="checkbox"/>
(c) Please provide latest transverse aortic diameter measurement and date obtained using measurement and date boxes.		
<input type="text"/> . <input type="text"/> cm	<input type="text" value="D"/>	<input type="text" value="D"/>
	<input type="text" value="M"/>	<input type="text" value="M"/>
	<input type="text" value="Y"/>	<input type="text" value="Y"/>
4. Dissection of the aorta repaired successfully?	<input type="checkbox"/>	<input type="checkbox"/>
If YES please provide copies of all reports to include those dealing with any surgical treatment.		
5. Is there a history of Marfan's disease?	<input type="checkbox"/>	<input type="checkbox"/>
If YES please provide relevant hospital notes.		

4D Valvular/Congenital Heart Disease

	YES	NO
Is there a history of, or evidence of, valvular/congenital heart disease?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
2. Is there a history of heart valve disease?	<input type="checkbox"/>	<input type="checkbox"/>

Patient's Name:

Date of Birth:

- 3. Is there a history of aortic stenosis? YES NO
If yes please provide relevant reports including echocardiogram

- 4. Is there any history of embolic stroke? YES NO

- 5. Does the patient currently have significant symptoms? YES NO

- 6. Has there been any progression (either clinically or on scans etc) since the last licence application? YES NO

4E Cardiac Other

- YES** **NO**
- Is there a history or evidence of heart failure? YES NO
- If **NO** go to **Section 4F**
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? YES NO
If yes please give details in Section 9

 - 3. Has a left ventricular assist device (LVAD) or other cardiac assist device implanted? YES NO

 - 4. A heart or lung transplant? YES NO

 - 5. Untreated atrial myxoma? YES NO

4F Cardiac channelopathies

- It there a history or evidence of the following conditions? YES NO
- 1. Brugada syndrome? YES NO

 - 2. Long QT syndrome YES NO
If yes to either please give details in Section 9 and enclose relevant hospital notes.

4G Blood Pressure

- YES** **NO**
- 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? YES NO
If YES please provide three previous readings with dates, if available
- | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| / | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="text-align: center;">D</td><td style="text-align: center;">D</td><td style="text-align: center;">M</td><td style="text-align: center;">M</td><td style="text-align: center;">Y</td><td style="text-align: center;">Y</td></tr> <tr><td style="text-align: center;">D</td><td style="text-align: center;">D</td><td style="text-align: center;">M</td><td style="text-align: center;">M</td><td style="text-align: center;">Y</td><td style="text-align: center;">Y</td></tr> <tr><td style="text-align: center;">D</td><td style="text-align: center;">D</td><td style="text-align: center;">M</td><td style="text-align: center;">M</td><td style="text-align: center;">Y</td><td style="text-align: center;">Y</td></tr> </table> | D | D | M | M | Y | Y | D | D | M | M | Y | Y | D | D | M | M | Y | Y |
| D | D | M | M | Y | Y | | | | | | | | | | | | | | |
| D | D | M | M | Y | Y | | | | | | | | | | | | | | |
| D | D | M | M | Y | Y | | | | | | | | | | | | | | |
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-
- 3. Is there a history of malignant hypertension? If yes please give details in Section 9 (including date of diagnosis and any treatment). YES NO

4H Cardiac Investigations

- YES** **NO**
- Have any cardiac investigations been undertaken or planned? YES NO
- If **NO** go to **Section 5**
If **YES** please answer all questions below and give details in **Section 9** of the form.
- 1. Has a resting ECG been undertaken? YES NO

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

If **YES**, does it show:

- | | | |
|--------------------------------|--------------------------|--------------------------|
| (a) pathological Q waves? | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) left bundle branch block? | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) right bundle branch block? | <input type="checkbox"/> | <input type="checkbox"/> |

Please provide a copy of any relevant reports or comment in section 9

-
2. Has an exercise ECG been undertaken (or planned)?

If **YES**, please give date and give details in **Section 9**

Please provide relevant reports

-
3. Has an echocardiogram been undertaken (or planned)?

(a) If **YES**, please give date and give details in **Section 9**

(b) If undertaken, is/was the left ventricular ejection fraction greater than or equal to 40%?

Please provide relevant reports

-
4. Has a coronary angiogram been undertaken (or planned)?

If **YES**, please give date and give details in **Section 9**

Please provide relevant reports

-
5. Has a 24 hour ECG tape been undertaken (or planned)?

If **YES**, please give date and give details in **Section 9**

Please provide relevant reports

-
6. Has a loop recorder been implanted (or planned)?

If **YES**, please give date and give details in **Section 9**

Please provide relevant reports

-
7. Has a Myocardial Perfusion Scan or Stress Echo study been undertaken (or planned)?

If **YES**, please give date and give details in **Section 9**

Please provide relevant reports

5 Psychiatric Illness

Is there a history of, or evidence of, psychiatric illness within the last 3 years? YES NO

If **NO**, please go to **Section 6**

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

NB If patient remains under specialist clinic(s) ensure details are filled in at the top of page 1

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

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

If **NO**, please go to **Section 7**

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

Patient's Name:

Date of Birth:

1. Is there a history of alcohol dependence within the last 6 years?
 (a) Is it controlled?
 (b) Has the applicant undergone an alcohol detoxification programme?

If yes, give date started:

D	D	M	M	Y	Y
---	---	---	---	---	---

2. Persistent alcohol misuse in the past 3 years
 (a) Is it controlled?

3. Use of illegal drugs or other substances, or misuse of prescription medication in the past 6 years?
 (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.

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

- i. Date of diagnosis

- ii. Is it controlled successfully?

- iii. If yes please state treatment

- iv. Is applicant compliant with treatment?

- v. Please state period of control:

years months

- vi. Date of last review

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 there a history of or evidence of narcolepsy? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Is there currently any functional impairment that is likely to impair control of the vehicle? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Is there a history of bronchogenic carcinoma or other malignant tumour with a significant liability to metastasise cerebrally? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Is there any illness that may cause significant fatigue or cachexia that affects safe driving? | | |

Patient's Name:

Date of Birth:

-
5. Is the patient profoundly deaf?
If **YES** is the patient able to communicate in the event of an emergency by speech or by using a device, e.g. a textphone?
-
6. Does the patient have a history of liver disease of any origin?
If **YES** is this the result of alcohol misuse?
If **YES**, please give details in **Section 9**
-
7. Is there a history of renal failure?
If **YES** give details in **Section 9**
-
8. Does the patient have severe symptomatic respiratory disease causing chronic hypoxia?
-
9. Does any medication currently taken cause the patient side effects that could affect safe driving?
If **YES**, please provide details of medication and symptoms
- | |
|--|
| |
| |
-
10. Does the patient have any other medical condition that could affect safe driving?
If **YES**, please provide details
- | |
|--|
| |
| |

Patient's Name:

Date of Birth:

9

Please forward copies of relevant hospital notes only. PLEASE DO NOT send any notes not related to fitness to drive

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 records 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	Date of Birth	<input type="text" value="D"/>	<input type="text" value="D"/>	<input type="text" value="M"/>	<input type="text" value="M"/>	<input type="text" value="Y"/>	<input type="text" value="Y"/>
Your address	Phone number	<input type="text"/>					
	Email address	<input type="text"/>					

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:	<input type="text"/>
Date:	<input type="text"/>

Patient's Name:

Date of Birth:

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.

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:	

Patient's Name:

Date of Birth: