



LICENSING TEAM, HEDGE END DEPOT, BOTLEY ROAD, HEDGE END SO30 2RA

Notes the Medical Practitioner

Please complete this form in full

Any fee charged is payable direct by the applicant to the medical Practitioner

Please confirm the identity of the applicant

Please post this form back to the council in the envelope provided

The Medical Commission on Accident Prevention has recommended that Group 2 medical standards applied by the DVLA should be applied by local authorities to Hackney Carriage and Private Hire vehicles drivers, see previous notes.

Name of Applicant

Address of Applicant

.....

.....

Date of Birth

National Insurance

Number

Is the applicant registered with your surgery Yes/No

Have you had access to the applicants Medical Records Yes/No

Council Use:

Satisfactory/Unsatisfactory

Notes

.....

.....

.....

Signature..... Date.....

LICENSING TEAM, EASTLEIGH BOROUGH COUNCIL, HEDGE END DEPOT, BOTLEY ROAD, HEDGE END. SOUTHAMPTON SO30 2RA

MEDICAL EXAMINATION - APPLICATION FOR HACKNEY CARRIAGE OR PRIVATE HIRE DRIVER'S LICENCE



This must be completed by your Doctor, taking into account the criteria for group 2 vocational drivers as set out in "medical aspects of fitness to drive" and the latest edition of the DVLA publication "at a glance guide for current medical standards of fitness to drive" (see note B1 above and section 7 of this report).

Please answer all questions and use black ink throughout

Please give the applicant's weight (kg/st) and height (cm/ft)

Please give details of smoking habits, if any

Please give the number of alcohol units taken each week

Details of specialist(s)/ consultants

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

Speciality

<input type="text"/>	<input type="text"/>	<input type="text"/>
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Date last seen

<input type="text"/>	<input type="text"/>	<input type="text"/>
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Current medication

Date first licensed to drive a hackney carriage and/or private hire vehicle

Section 1 - Vision (Please see **eyesight notes** on page 2)

Please tick ✓ the appropriate boxes

A medical standard of at least 6/60 in the worst eye, and 6/7.5 in the better eye is normally required.

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Does the patient's vision reach this standard without glasses or contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. If no, does the patient's vision reach this standard with glasses or contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> |
| If Yes, | | |
| (c) If correction is required to meet the above standard, is it well tolerated? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Please state the visual acuities of each eye in terms of the 6 metre Snellen chart. Please convert any 3 metre readings to the 6 metre equivalent | | |

Uncorrected

Right Left

Corrected (if applicable)

Right Left

Note 1: It is not necessary to record the uncorrected acuity if the patient requires glasses or contact lenses to reach the above standard.

Note 2: In exceptional circumstances a person who has held a licence for many years may be permitted to hold a licence with vision which fails to meet the above acuity standards. The examining doctor is advised to consult the DVLA publication 'At a Glance Guide' or seek further guidance in these cases.

A patient must not require spectacles which have lenses of +8 dioptries or greater.

4. Does the patient require spectacles of +8 dioptries or greater to meet the above visual acuity requirement?

Note3: It may be necessary for the patient to obtain a declaration from an optometrist to confirm this.

5. Is there a defect in the patient's binocular field of vision (central and/or peripheral)?
6. Is there diplopia (controlled or uncontrolled)?
7. Does the applicant have any other ophthalmic condition?

If **Yes** to 4, 5, or 6, please give details in **section 7** and enclose any relevant visual field charts or hospital letters.

Section 2 - Nervous System

	Yes	No
1. Has the applicant had any form of epileptic attack? If Yes , please give date of last attack If treated, please give date when treatment ceased	<input type="checkbox"/>	<input type="checkbox"/>
2. Is there a history of blackout or impaired consciousness within the last 5 years? If Yes , please give dates and details in section 7	<input type="checkbox"/>	<input type="checkbox"/>
3. Does the applicant suffer from narcolepsy/cataplexy? If Yes , please give dates and details in section 7	<input type="checkbox"/>	<input type="checkbox"/>
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 boxes and give dates and full details at section 7	<input type="checkbox"/>	<input type="checkbox"/>
(a) Stroke/TIA <i>please delete as appropriate</i>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Sudden and disabling dizziness/vertigo within the last year with a liability to recur	<input type="checkbox"/>	<input type="checkbox"/>
(c) Subarachnoid haemorrhage	<input type="checkbox"/>	<input type="checkbox"/>
(d) Serious head injury with the last 10 years	<input type="checkbox"/>	<input type="checkbox"/>
(e) Brain tumour, either benign or malignant, primary or secondary	<input type="checkbox"/>	<input type="checkbox"/>
(f) Other brain surgery	<input type="checkbox"/>	<input type="checkbox"/>
(g) Chronic neurological disorders e.g. Parkinson's disease, Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
(h) Dementia or cognitive impairment	<input type="checkbox"/>	<input type="checkbox"/>

Section 3 - Diabetes Mellitus

	Yes	No
1. Does the applicant have diabetes mellitus? If No , go to section 4 If Yes , please answer the following questions	<input type="checkbox"/>	<input type="checkbox"/>
2. Is the diabetes managed by: -		
(a) Insulin? If Yes , please give date started on insulin	<input type="checkbox"/>	<input type="checkbox"/>
(b) Oral hypoglycaemic agents and diet?	<input type="checkbox"/>	<input type="checkbox"/>
(c) Diet only?	<input type="checkbox"/>	<input type="checkbox"/>
3. Does the applicant test blood glucose at least twice every day?	<input type="checkbox"/>	<input type="checkbox"/>
4. 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?	<input type="checkbox"/>	<input type="checkbox"/>
(c) Diminished/absent awareness of hypoglycaemia?	<input type="checkbox"/>	<input type="checkbox"/>
5. Has there been laser treatment for retinopathy? If Yes , please give date(s) of treatment	<input type="checkbox"/>	<input type="checkbox"/>
6. Is there a history of hypoglycaemia during waking hours in the last 12 months requiring assistance from a third party?	<input type="checkbox"/>	<input type="checkbox"/>
7. If Yes to any of 4-6 above, please give details in section 7	<input type="checkbox"/>	<input type="checkbox"/>

Section 4 - Psychiatric illness

	Yes	No
Is there a history, or evidence, of any of the conditions listed at 1-6 below? If No go to section 5 If Yes please tick the relevant box(es) below and give dates, 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 entered in section 1	<input type="checkbox"/>	<input type="checkbox"/>
1. Significant psychiatric disorder within the past 6 months, e.g. depression	<input type="checkbox"/>	<input type="checkbox"/>
2. A psychotic illness within the past 3 years, e.g. schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>
3. Persistent alcohol misuse in the past 12 months	<input type="checkbox"/>	<input type="checkbox"/>
4. Alcohol dependency in the past 3 years	<input type="checkbox"/>	<input type="checkbox"/>
5. Persistent drug misuse in the past 12 months	<input type="checkbox"/>	<input type="checkbox"/>
6. Drug dependency in the past 3 years	<input type="checkbox"/>	<input type="checkbox"/>

Section 5 - Cardiac

Please follow the instructions in all **sections 5A – 5G** giving details as required at **section 7**.
NB. If applicant remain under specialist cardiac clinic(s) ensure details are completed in **section 1**

Section 5A - Coronary Artery Disease

Is there a history, or evidence, of coronary artery disease?

Yes	No

If **No**, go to section 5 B

If **Yes** please answer all questions below and give details at **section 7**

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 date of the last attack

Section 5B - Cardiac Arrhythmia

	Yes	No
Is there a history, or evidence, of cardiac arrhythmia?	<input type="checkbox"/>	<input type="checkbox"/>
If No , go to section 5C		
If Yes please answer all questions below and give details at section 7		
1. Has the applicant had a significant documented disturbance in cardiac rhythm within the past 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 a cardiac defibrillator device been implanted?	<input type="checkbox"/>	<input type="checkbox"/>
4. Has a pacemaker been implemented?	<input type="checkbox"/>	<input type="checkbox"/>
If Yes : -		
(a) Has a pacemaker been implanted for at least 6 weeks?	<input type="checkbox"/>	<input type="checkbox"/>
(b) Since implantation, is the patient now symptom free from this condition?	<input type="checkbox"/>	<input type="checkbox"/>
(c) Does the applicant attend a pacemaker clinic regularly?	<input type="checkbox"/>	<input type="checkbox"/>

Section 5C - Peripheral Arterial Disease

	Yes	No
Is there a history, or evidence, of ANY of the following:	<input type="checkbox"/>	<input type="checkbox"/>
If Yes , please tick ✓ all relevant boxes below, and give details at section 7		
	Yes	No
1. Peripheral Arterial Disease?	<input type="checkbox"/>	<input type="checkbox"/>
2. Aortic Aneurysm? If Yes :	<input type="checkbox"/>	<input type="checkbox"/>
(a) Site of Aneurysm	Thoracic	Abdominal
(b) Has it been repaired successfully?	<input type="checkbox"/>	<input type="checkbox"/>
(c) Is the transverse diameter more than 5 cms?	<input type="checkbox"/>	<input type="checkbox"/>
3. Dissection of the Aorta? If Yes :	<input type="checkbox"/>	<input type="checkbox"/>
(a) Has it been repaired successfully?	<input type="checkbox"/>	<input type="checkbox"/>

Section 5D - Valvular / Congenital Heart Disease

	Yes	No
Is there a history, or evidence, of valvular / congenital heart disease?	<input type="checkbox"/>	<input type="checkbox"/>
If No , go to section 5E		
If Yes , please answer all questions below, and give details at section 7		
1. Is there a history of congenital heart disorder?	<input type="checkbox"/>	<input type="checkbox"/>
2. Is there a history of heart valve disease?	<input type="checkbox"/>	<input type="checkbox"/>
3. Is there a history of embolism? (not pulmonary embolism)	<input type="checkbox"/>	<input type="checkbox"/>
4. Does the applicant currently have significant symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
5. Has there been any progression since the last licence application? (if relevant)	<input type="checkbox"/>	<input type="checkbox"/>

Section 5E - Cardiomyopathy

	Yes	No
Does the applicant have a history of any of the following conditions:	<input type="checkbox"/>	<input type="checkbox"/>
(a) A history, or evidence, of heart failure?	<input type="checkbox"/>	<input type="checkbox"/>
(b) Established cardiomyopathy?	<input type="checkbox"/>	<input type="checkbox"/>
(c) A heart of heart/lung transplant?	<input type="checkbox"/>	<input type="checkbox"/>

If **Yes** to any part of the above, please give full details in **section 7**

Section 5F - Cardiac Investigations

This section must be completed for all applicants

	Yes	No
1. Has a resting ECG been undertaken	<input type="checkbox"/>	<input type="checkbox"/>
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"/>
2. Has an exercise ECG been undertaken (or planned)?	<input type="checkbox"/>	<input type="checkbox"/>
If Yes , give date and give details in section 7		
<i>Sight/copy of the exercise test result/report (if done in the last 3 years) would be useful</i>		
3. Has an echocardiogram been undertaken (or planned)?	<input type="checkbox"/>	<input type="checkbox"/>
If Yes , give date and give details in section 7		
<i>Sight/copy of the echocardiogram result/report would be useful</i>		
4. Has a coronary angiogram been undertaken (or planned)?	<input type="checkbox"/>	<input type="checkbox"/>
If Yes , give date and give details in section 7		
<i>Sight/copy of the angiogram result/report would be useful</i>		
5. Has a 24 hour ECG tape been undertaken (or planned)?	<input type="checkbox"/>	<input type="checkbox"/>
If Yes , give date and give details in section 7		
<i>Sight/copy of the 24 hour tape result/report would be useful</i>		
6. Has a myocardial perfusion imaging scan been undertaken (or planned)?	<input type="checkbox"/>	<input type="checkbox"/>
7. If Yes , give date and give details in section 7		

Section 5G - Blood Pressure

This section must be completed for all applicants

	Yes	No
1. Is today's systolic pressure greater than 180?	<input type="checkbox"/>	<input type="checkbox"/>
2. Is today's diastolic pressure greater than 100?	<input type="checkbox"/>	<input type="checkbox"/>
3. Is the applicant on anti-hypertensive treatment?	<input type="checkbox"/>	<input type="checkbox"/>
4. If Yes to any of the above, please supply today's reading:	<input type="text"/>	

Section 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Is there a history of bronchogenic carcinoma or other malignant tumour, for example, malignant melanoma, with significant liability to metastasise cerebrally? | <input type="checkbox"/> | <input type="checkbox"/> |

If **Yes**, please give dates and diagnosis and state whether there is current evidence of dissemination

- | | | |
|---|--------------------------|--------------------------|
| 3. Is the applicant profoundly deaf? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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/textphone | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Is there a history of either renal or hepatic failure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Does the applicant have apnoea syndrome? | <input type="checkbox"/> | <input type="checkbox"/> |
| If Yes , has it been controlled successfully? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Is there any other medical condition causing excessive daytime sleepiness? | <input type="checkbox"/> | <input type="checkbox"/> |

If **Yes**, please give full details below

- | | | |
|--|--------------------------|--------------------------|
| 7. Does the applicant have severe symptomatic respiratory disease causing chronic hypoxia? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Does any medication currently taken cause the applicant side effects which impair his/her safe driving? | <input type="checkbox"/> | <input type="checkbox"/> |

Section 7 – Please forward copies of all relevant hospital notes if available

Section 8 Applicant's consent and declaration

This section must be completed and must not be altered in any way

Consent and Declaration Please read the following important information carefully then sign and date the statements below

On occasion, as part of the investigation into your fitness to drive a hackney carriage or private hire vehicle, Eastleigh 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 medical background 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. In addition, where the circumstances of your case appear exceptional, the relevant medical information would need to be considered by members of the borough Council's Licensing panel. Such information would be subject to legal restrictions on confidentiality.

Consent and Declaration

I authorise my Doctor(s) and Specialist(s) to release reports to Eastleigh Borough Councils Licensing Authority about my condition.

I authorise Eastleigh Council to disclose such relevant medical information as may be necessary to the investigation of my fitness to drive, to all those involved in the determination of my application for a licence, 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 this form and that, to the best of my knowledge and belief, they are correct.

Signature Date

Section 9 - 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

Name	<input type="text"/>	Date of Birth	<input type="text"/>
Address	<input type="text"/>	Home 'phone	<input type="text"/>
	<input type="text"/>	Daytime 'phone	<input type="text"/>
	<input type="text"/>		
Post Code	<input type="text"/>		
E-mail address	<input type="text"/>		

Section 10 – Medical Practitioner Details

To be completed by the Medical Practitioner carrying out the examination

Name	<input type="text"/>	Surgery Stamp
Address	<input type="text"/>	
	<input type="text"/>	
Post Code	<input type="text"/>	
E-mail address	<input type="text"/>	

	YES	NO
The applicant is registered with this surgery/practise as a patient	<input type="checkbox"/>	<input type="checkbox"/>
The applicant has been referred to me by their own GP practise Letter of referral is attached to this report.	<input type="checkbox"/>	<input type="checkbox"/>
I have full access to the patient's medical records	<input type="checkbox"/>	<input type="checkbox"/>
I consider that the applicant meets the criteria for Group 2 Vocational Driver's Licence as set out in the latest editions of the DVLA publication	<input type="checkbox"/>	<input type="checkbox"/>

"For Medical Practitioners – at a Glance Guide for Current Medical Standards Of Fitness to Drive" and the Medical Commission on Accident Prevention's publication "Medical Aspects of Fitness to Drive".

THE EXAMINING GP IS REQUIRED TO HAVE FULL ACCESS TO THE APPLICANTS MEDICAL RECORDS IN ORDER TO ASSESS IF THEY ARE OR ARE NOT FIT TO BE A VOCATIONAL DRIVER

GMC registration no.:	<input type="text"/>								
Signature of Medical Practitioner	<input type="text"/>						Date	<input type="text"/>	

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