Cheshire West & Chester Borough Council

Driver medical assessment to DVLA – "Assessing fitness to drive: a guide for medical professionals" Group 2 Standards (as amended)

This form must be filled out by the medical examiner only, who must have full access to the applicant's medical records.

- Please ensure you verify the applicants identity before proceeding
- Please ensure you fully examine the applicant as well as taking the applicants medical history.
- Please answer all of the questions within the form before signing the declaration.

Name of applicant:	
Address:	
Date of birth:	

Guidance Notes

This report is for the confidential use of the Licensing Authority. Medical Practitioners are asked to complete the form in full and return it to the applicant. Please note that the form must be signed by you and endorsed with your practice stamp. Any fee charged upon examination or as a result of any further enquiry is payable by the applicant.

Any person granted a dual Private Hire and Hackney Carriage driver's licence is in a position whereby they are responsible for the safety of the travelling public. It is therefore extremely important that Medical Practitioners consider very seriously whether or not the applicant has any medical issue that could result in them not meeting Group 2 of the UK medical standards for driver licensing.

All drivers are expected to transport and assist with wheelchairs, assistance dogs and luggage. Please ensure you have considered all these potential scenarios before / when completing this form.

Part 1 – Nervous System

1.	Has the applicant ever experienced any form of seizure? **(If no, proceed to question 2)**			Yes		No	
(a)	Has the applicant had more than one attack?			Yes		No	
(b)	Please give the dates of the first and last attacks.	First attack		Last attack			
(c)	Is the applicant currently on anti-epileptic medication?			Yes		No	
(d)	If the applicant is no longer under treatment, please give the date when treatment ended?						
(e)	Has the applicant had a brain scan?			Yes		No	
	If yes, please provide details						
(f)	Has the applicant had an EEG?			Yes		No	
	If yes, please provided details and append reports if available.						
2.	Is there a history of blackout or impaired consciousness within the last five years?			Yes		No	
	If yes, please provide details and dates						
3.	Does the applicant suffer from narcolepsy or cataplexy?			Yes		No	
	If yes, please provide details and dates						

4.	Is there a history, or any evidence of any of the following conditions? **Please answer all questions (a) to (h)**				
(a)	Stroke or TIA?	Yes		No	
	If yes, please provide the date				
	Has there been a **full** recovery?	Yes		No	
	Has a carotid ultra sound been performed?	Yes		No	
(b)	Sudden and disabling dizziness / vertigo within the last year with a liability to recur?	Yes		No	
(c)	Subarachnoid haemorrhage?	Yes		No	
(d)	Serious traumatic brain injury within the last ten years?	Yes		No	
(e)	Any form of brain tumour?	Yes		No	
(f)	Other brain surgery or abnormality?	Yes		No	
(g)	Chronic neurological disorders?	Yes		No	
(h)	Parkinson's disease?	Yes		No	

Part 2 – Diabetes Mellitus

5.	Does the applicant have diabetes mellitus? **(If no, please got to part three)**	Yes		No	
6.	Is the diabetes treated by insulin?	Yes		No	
(a)	If yes, please provide the date insulin injections were started?				
(b)	If treated with insulin, are there at least three months of blood glucose readings stored on a memory meter?	Yes		No	
	If no, please give details				
(c)	Is the diabetes treated by other injectable treatments?	Yes		No	
(d)	Is the diabetes treated by a Sulphonylurea or a Glinide?	Yes		No	
(e)	Is the diabetes treated by oral hypoglycaemic agents and diet?	Yes		No	
	If you have answered yes to any of (a) to (e), please provide details				

(f)	Is the diabetes treated by diet alone?	Yes		No	
7. (a)	Does the applicant test blood glucose at least twice every day?	Yes		No	
(b)	Does the applicant test at times relevant to driving?	Yes		No	
(c)	Does the applicant keep fast acting carbohydrate within easy reach when driving?	Yes		No	
(d)	Does the applicant have a clear understanding of diabetes and the necessary precautions for safe driving?	Yes		No	
8.	Is there evidence of impaired awareness of hypoglycaemia?	Yes		No	
9.	Is there a history of hypoglycaemia in the last twelve months requiring the assistance of another person?	Yes		No	
10.	Is there evidence of a loss of visual field?	Yes		No	
11.	Is there evidence of sever peripheral neuropathy, sufficient to impair limb function for safe driving?	Yes		No	
	If you have answered yes to 8. 9. or 10. please provide details				
12.	Has there been laser eye treatment or intra-vitreal treatment for retinopathy?	Yes		No	
	If yes, please provide details and date(s) of treatment				

Part 3 – Psychiatric Illness

13.	Is there a history of, or evidence of, any of the following conditions?				
(a)	Significant psychological disorder within the last six months?	Yes		No	
(b)	Psychosis or hypomania / mania within the past three years, including psychotic depression?	Yes		No	
(c)	Dementia or cognitive impairment?	Yes		No	
(d)	Persistent alcohol misuse in the past twelve months?	Yes		No	
(e)	Alcohol dependence in the last three years?	Yes		No	
(f)	Persistent drug misuse in the past twelve months?	Yes		No	
(g)	Drug dependence in the past three years?	Yes		No	

	If you have answered yes to any of the above, please provide details including hospital notes and any specialists seen. If you have answered yes to any of (d) to (g), provide details of past consumption, name of drugs, frequency of use and how long this has been controlled.

Part 4 - Cardiac

	Coronary Artery Disease				
14.	Is there a history, or evidence of, coronary artery disease? **(If no, go to question 15)**	Yes		No	
(a)	Has the applicant suffered from angina?	Yes		No	
	If yes, please give the date of the last attack?				
(b)	Acute coronary syndromes including myocardial infarction?	Yes		No	
	If yes, please give the date?				
(c)	Coronary angioplasty (P.C.1)?	Yes		No	
	If yes, please give the date of the most recent intervention?				
(d)	Coronary artery by-pass graft surgery?	Yes		No	
	If yes, please give the date?				

	If you have answered yes to any of the above, please give details and enclose relevant hospital notes (if available).

	Cardiac Arrhythmia				
15.	Is there a history, or any evidence of, cardiac arrhythmia? **(If no, go to question 16)**	Yes		No	
(a)	Has there been a significant disturbance of cardiac rhythm i.e. sinoatrial disease, significant atrio-ventricular conduction defect, atrial flutter / fibrillation, narrow or broad complex tachycardia in the last five years?	Yes		No	
(b)	Has the arrhythmia been controlled satisfactorily for at least three months?	Yes		No	
(c)	Has an ICD or biventricular pacemaker (CRST-D Type) been implanted?	Yes		No	
(d)	Has a pacemaker been implanted?	Yes		No	
	If yes, please supply the date?				
	Is the applicant now free of the symptoms that caused the device to be fitted?	Yes		No	
	Does the applicant attend a pacemaker clinic regularly?	Yes		No	

	Peripheral Arterial Disease (excluding Buerger's disease) **Aortic Aneurysm / Dissection**				
16.	Is there a history, or evidence of, any of the following conditions?				
(a)	Peripheral arterial disease? (Excluding Bueger's disease)	Yes		No	
(b)	Does the applicant have claudication?	Yes		No	
	If yes, for how long (in minutes) can the applicant walk at a brisk pace before becoming symptom limited?				
(c)	Aortic aneurism?	Yes		No	
	If yes, site of aneurism: Thoracic		Abdominal		
	Has it been repaired successfully?	Yes		No	
	Is the transverse diameter currently less than 5.5cm?	Yes		No	
	If no, please provide the latest measurement and the date obtained?				

(d)	Dissection of the aorta repaired successfully? (If yes, please append copies of all reports detailing surgical treatment)	Yes		No	
(e)	Is there a history of Marfan's disease? (If yes, please append relevant hospital notes)	Yes		No	

	Valvular / Congenital Heart Disease				
17.	Is there a history, or evidence of, valvular / congenital heart disease? **(If no, please go to question 18)**	Yes		No	
(a)	Is there a history of congenital heart disorder?	Yes		No	
(b)	Is there a history of heart valve disease?	Yes		No	
(c)	Is there a history of embolism? (Not pulmonary embolism)	Yes		No	
(d)	Does the applicant currently have significant symptoms?	Yes		No	
(e)	Has there been any progression since the last licence application? (If relevant)	Yes		No	
	If you have answered yes to any of the above questions, please provide details.				

	Other Cardiac Issues				
18.	Does the applicant have a history, or is there evidence, of any of the following conditions?				
(a)	Heart failure?	Yes		No	
(b)	Established cardiomyopathy?	Yes		No	
(c)	Has a Left Ventricular Assist Device been implanted?	Yes		No	
(d)	Heart or heart / lung transplant?	Yes		No	
(e)	Untreated atrial myxoma?	Yes		No	
	If you have answered yes to any of the above questions, please provide details.				

	Cardiac Investigations				
19.	Has a resting ECG been undertaken? If yes, does it show the following	Yes		No	
(a)	Pathological Q waves?	Yes		No	
(b)	Left bundle branch block?	Yes		No	
(c)	Right bundle branch block?	Yes		No	
	If you have answered yes to any of the above questions, please provide details and append the relevant ECG report (if available).				

20.	Has an exercise ECG been undertaken?	Yes		No	
	If yes, please provide the date and give details.				
	.				
21.	Has an echocardiogram been undertaken? (If yes, please provide the date and give details below)	Yes		No	
	.				
(a)	Was the left ejection fraction greater than or equal to 40%?	Yes		No	
22.	Has a coronary angiogram been undertaken? (If yes, please provide the date and give details below)	Yes		No	
	.				

23.	Has a 24 hour ECG tape been undertaken? (If yes, please provide the date and give details below)	Yes		No	
	.				
24.	Has a myocardial perfusion scan or stress echo study been undertaken? (If yes, please provide the date and give details below)	Yes		No	
	.				

	Blood Pressure					
25.	Please record today's blood pressure reading:					
(a)	Is the driver on anti-hypertensive treatment? If yes, please provide three previous readings with the dates on which they were taken.		Yes		No	
	1st reading		Date			
	2nd reading		Date			
	3rd reading		Date			

Part 5 - General

26.	**If you answer yes to any of the following questions, please give details in the space provided at the end of this section**				
(a)	Is there currently any functional impairment that is likely to affect control of the vehicle?	Yes		No	
(b)	Is there a history of bronchogenic carcinoma or other malignant tumour with a significant liability to metastasise cerebrally?	Yes		No	
(c)	Is there any illness that may cause significant fatigue or cachexia that affects safe driving?	Yes		No	
(d)	Is the applicant profoundly deaf?	Yes		No	

	If yes, is the applicant able to communicate in the event of an emergency by speech or by using a device, e.g. textphone?	Yes		No	
(e)	Is there a history of renal failure?	Yes		No	
(f)	Is there a history of, or evidence of, obstructive sleep apnoea syndrome?	Yes		No	
	Is there any other medical condition causing excessive sleepiness?	Yes		No	
	If yes, please give the date of diagnosis.				
	Is it controlled successfully?	Yes		No	
	If yes, please state the treatment being undertaken?				
	Please state the period of control:				
	Date last seen by consultant:				
(g)	Does the applicant have severe symptomatic respiratory disease causing chronic hypoxia?	Yes		No	
(h)	Does any medication currently taken cause the applicant side effects that could affect safe driving?	Yes		No	
(i)	Does the applicant have an ophthalmic condition?	Yes		No	
(j)	Does the applicant have any other medical condition that could affect safe driving?	Yes		No	

	If you have answered yes to any of the above, please give details and enclose relevant hospital notes (if available).

Part 6 – Consultants Details

	Details of types of specialists/consultants	
	Consultant in:	
	Name:	
	Address:	

	Details of types of specialists/consultants	
	Consultant in:	
	Name:	
	Address:	

	Details of types of specialists/consultants	
	Consultant in:	
	Name:	
	Address:	

Part 7 – Medication

	Please provide details of all current medication (continue on a separate sheet if necessary).	
	Medication:	
	Dosage:	
	Reason for taking:	

	Medication:	
	Dosage:	

	Reason for taking:	

	Medication:	
	Dosage:	
	Reason for taking:	

	Medication:	
	Dosage:	
	Reason for taking:	

Part 8 – Additional Information

	Patients weight:	
	Height (cms):	
	Details of smoking habits (if any):	
	Number of alcohol units consumed each week:	

Part 9 - Driver Visual Assessment

To be completed by a doctor or optician / optometrist. The visual acuity, as measured by the 6 metre Snellen chart, must be at least 6/7.5 (decimal Snellen equivalent 0.8) in the better eye and at least Snellen 6/60 (decimal Snellen equivalent 0.1) in the other eye. Corrective lenses may be worn to achieve this standard. A LogMAR reading is acceptable.`

1.	Please state the visual acuity of each eye - please express the visual acuity as Snellen only and not Snellen expressed as a decimal or logMAR			
	Uncorrected		**Corrected**	
	Right	Left	Right	Left

2.	Please give the best binocular acuity with corrective lenses if worn for driving?				
3.	If glasses were worn, was the distance spectacle prescription of either lens used of a corrective power greater than plus 8 (+8) dioptres?	Yes		No	
4.	If a correction is worn for driving, is it well tolerated?	Yes		No	
	If you answer yes to any of the following questions, please ensure you give full details in the box provided below.				
5.	Is there a history of any medical condition that may affect the applicant's binocular field of vision (central and / or peripheral)?	Yes		No	
6.	Is there diplopia?	Yes		No	
	If yes, is it controlled?	Yes		No	
7.	Is there any reason to believe that there is impairment of contrast sensitivity or intolerance to glare?	Yes		No	
8.	Does the applicant have any other ophthalmic condition?	Yes		No	

	If you have answered yes to any of questions 5 to 8, please give details in the box below.

	Name of applicant:	

	Date of examination:	

	Name of examiner:	
	Signature:	
	Date of signature:	

	Please provide your GOC, HPC or GMC Number:	

Doctor/optometrist/opticians practice stamp:

Part 10 – Examining Doctor's Certification

Please complete all sections:	
Surgery/Practice Name:	Surgery/practice Stamp:
Surgery/practice Address:	
Name of Doctor	Date of medical assessment
Registration Number	

☐ I am, the applicants GP and have access to the applicant's full medical records. I have undertaken an identity check against a valid photo id document (valid passport or DVLA photo card) that fully match the details of the Medical. Form.

Type of photo ID seen –

OR

☐ I am a doctor and have had access to the applicant's medical records (including on-line medical records access) or has seen a recent Medical Summary provided by the applicants GP and undertaken an identity check against a valid photo id document (valid passport or DVLA photo card) that fully match the details on the Medical Summary.

Type of Photo ID seen -

I have assessed the applicant for

Medical excluding visual assessment ☐

Medical including visual assessment ☐

I confirm the applicant:

Meets DVLA Group 2 Medical Standards ☐

Does NOT meet DVLA Group 2 Medical Standards ☐

Please add any additional details which the Licensing Authority should be aware of (continue on separate sheet if necessary).

Part 11 – Applicant's Declaration

I authorise the release of medical information within this form to the Licensing Department, Cheshire West and Chester Council.

I am aware this information will be solely used in connection with my Private Hire / Hackney Carriage drivers licence and in accordance with the General Data Protection Regulations and Privacy Statement

Name of applicant:	
Signature:	
Date:	