Medical examination report for a Hackney carriage and/or private hire licence

Please note:

All boxes outlined in **blue** must be completed.
The front and back page must be filled in by the applicant.
If you do not complete this form fully, we will have to return it to you and the application will be delayed.

For the applicant:
This medical report cannot be issued free of charge as part of the National Health Service. The applicant must pay the medical practitioner's fee, unless other arrangements have been made. The Licensing Authority accepts no liability to pay it.

For the examining medical practitioner:
The fee payable for this examination is to be paid by the applicant for the Licence and the Licensing Authority accepts no liability to pay the fee. **For form continuity, please sign the top of every page in the box provided.**

Your details

Your name

Address and postcode

Date of birth / /

Phone number

Email address

Your doctor's details

Name of doctor

Address and postcode of surgery

Phone number

Email address (if known)

You must sign and date the declaration on the back page when the doctor and optician have the report.

Vision assessment

This section is to be filled in by a doctor or optician/optometrist. If correction is needed to meet the eyesight standard for driving, you must answer **all** questions. If correction is **not** needed, you can ignore questions 5 and 6.

1. Please confirm the scale you are using to express the driver's visual acuities.

☐ Snellen ☐ Snellen expressed as a decimal ☐ LogMAR

2. Please state the visual acuity of 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 by an optician.

	Uncorrected		Corrected (using prescription worn for driving)	
	R	L	R	L

3. Is the visual acuity at least 6/7.5 in the better eye and at least 6/60 in the other eye (corrective lenses may be worn to meet this standard)? ☐ Yes ☐ No

4. Were corrective lenses worn to meet this standard? ☐ Yes ☐ No

If **yes**, were they: ☐ Glasses ☐ Contact lenses ☐ Both together

5. If glasses (not contact lenses) are worn for driving, is the corrective power greater than plus (+)8 dioptres in any meridian of either lens? ☐ Yes ☐ No

6. If correction is worn for driving, is it well tolerated?
If **no**, please give full details in the box provided. ☐ Yes ☐ No

If you answer yes to any of the following, please give details in the box provided.

7. Is there a history of any medical condition that may affect the applicant's binocular field of vision (central and/or peripheral)? ☐ Yes ☐ No

8. Is there diplopia? ☐ Yes ☐ No **a) If yes, is it controlled?** ☐ Yes ☐ No

9. Does the applicant on questioning, report symptoms of intolerance to glare and/or impaired contrast sensitivity and/or impaired twilight vision? ☐ Yes ☐ No

10. Does the applicant have any other ophthalmic condition? ☐ Yes ☐ No

Details/additional information

Name of examining doctor/optician (print)

Signature of examining doctor/optician

Date of signature / /

GOC, HPC or GMC no.

Doctor/optometrist/opticians stamp

Medical assessment

Signature

This section must be filled in by a doctor. Please check the applicant's identity before you proceed.
Please ensure you fully examine the applicant as well as taking the applicant's history.

1 Neurological disorders

Is there a history of, or evidence of, any neurological disorder? ☐ Yes ☐ No

If **no,** please go to section 2.
If **yes**, please answer **all** of the questions in section 1.

1. Has the applicant had any form of seizure? ☐ Yes ☐ No

a) Has the applicant had more than one attack? ☐ Yes ☐ No

b) Please give the dates of the first and last attack. First / / Last / /

c) Is the applicant currently on anti-epileptic medication? ☐ Yes ☐ No

If **yes**, please fill in current medication in **section 8.**

d) If no longer treated, please give date when treatment ended. / /

e) Has the applicant had a brain scan? ☐ Yes ☐ No

If **yes**, please give details in **section 6.**

f) Has the applicant had an EEG? ☐ Yes ☐ No

If **yes** to any of the above, please supply reports if available.

Is there **any** history of the following: (If **yes** to any of these, please give details and dates in section 6)

2. Stroke or TIA? ☐ Yes ☐ No

a) If yes, please give the date / / **b) Has there been a full recovery?** ☐ Yes ☐ No

c) Has a carotid ultra sound been undertaken? ☐ Yes ☐ No

d) Has there been a carotid endarterectomy? ☐ Yes ☐ No

If **yes**, was the carotid artery senosis more than 50%? ☐ Yes ☐ No

3. Sudden and disabling dizziness/vertigo within the last year with a liability to recur? ☐ Yes ☐ No

4. Subarachnoid haemorrhage? ☐ Yes ☐ No

5. Serious traumatic brain injury within the last 10 years? ☐ Yes ☐ No

6. Any form of brain tumour? ☐ Yes ☐ No

7. Other brain surgery or abnormality? ☐ Yes ☐ No

8. Chronic neurological disorders? ☐ Yes ☐ No

9. Parkinson's disease? ☐ Yes ☐ No

10. Is there a history of blackout or impaired consciousness within the last 5 years? ☐ Yes ☐ No

11. Does the applicant suffer from narcolepsy? ☐ Yes ☐ No

2 Diabetes mellitus

Signature

Does the applicant have diabetes mellitus? ☐ Yes ☐ No

If **no**, please go to section 3.
If **yes**, please answer **all** of the questions in section 2.

1. Is the diabetes managed by:

a) Insulin? ☐ Yes ☐ No If **yes**, please give the date insulin was started / /

If **no**, please give details in section 6.

b) If treated with insulin, are there at least 3 cotinuous months of blood glucose readings stored on a memory meter(s)? ☐ Yes ☐ No

c) Other injectable treatments? ☐ Yes ☐ No

d) A Sulphonylurea or a Glinide? ☐ Yes ☐ No

e) Oral hypoglycaemic agents and diet? ☐ Yes ☐ No

If **yes** to any of a-e, please fill in current medication in section 8.

f) Diet only? ☐ Yes ☐ No

2. Does the applicant:

a) Test blood glucose at least twice every day? ☐ Yes ☐ No

b) Test at times relevant to driving?
(No more than 2 hours before the start of the first journey and every 2 hours while driving). ☐ Yes ☐ No

c) Keep fast acting carbohydrate within easy reach when driving? ☐ Yes ☐ No

d) Have a clear understanding of diabetes and the necessary precautions for safe driving? ☐ Yes ☐ No

3. Is there any evidence of impaired awareness of hypoglycaemia? ☐ Yes ☐ No

4. Is there a history of hypoglycaemia in the last 12 months requiring the assistance of another person? ☐ Yes ☐ No

5. Is there evidence of:

a) Loss of visual field? ☐ Yes ☐ No

b) Severe peripheral neuropathy, sufficient to impair limb function for safe driving? ☐ Yes ☐ No

6. Has there been laser treatment or intra-vitreal treatment for retinopathy? ☐ Yes ☐ No

a) If yes, please give date(s) of treatment

If **yes** to any of questions 4-5, please give details in section 6

3 Psychiatric illness

Is there a history of, or evidence of, psychiatric illness, drug/alcohol misuse within the last 3 years? ☐ Yes ☐ No

If **no**, please go to section 4.
If **yes**, please answer **all** of the questions in section 3.

1. Significant psychiatric disorder within the past 6 months? ☐ Yes ☐ No

2. Psychosis or hypomania/mania within the past 12 months, including psychotic depression? ☐ Yes ☐ No

3. Dementia or cognitive impairment? ☐ Yes ☐ No

Signature

4. **Persistent alcohol misuse in the past 12 months?** ☐ Yes ☐ No

5. **Alcohol dependence in the past 3 years?** ☐ Yes ☐ No

6. **Persistent drug misuse in the past 12 months?** ☐ Yes ☐ No

7. **Drug dependence in the past 3 years** ☐ Yes ☐ No

If **yes** to any of questions in this section, please provide full details in section 6, including dates, period of stability and where appropriate consumption and frequency of use.

4 Cardiac

a Coronary artery disease

Is there a history of, or evidence of, coronary artery disease? ☐ Yes ☐ No

If **no**, please go to section 4b. If **yes**, please answer **all** of the questions in section 4a and give details in section 6 of the form and enclose relevant hospital notes.

1. **Has the applicant suffered from angina?** ☐ Yes ☐ No

   If **yes**, please give the date of the last known attack / /

2. **Acute coronary syndrome including myocardial infarction?** ☐ Yes ☐ No

   If **yes**, please give the date / /

3. **Coronary angioplasty (P.C.I.)?** ☐ Yes ☐ No

   If **yes**, please give the date of most recent intervention / /

4. **Coronary artery by-pass graft surgery?** ☐ Yes ☐ No

   If **yes**, please give the date / /

b Cardiac arrhythmia

Is there a history of, or evidence of, cardiac arrhythmia ☐ Yes ☐ No

If **no**, please go to section 4c. If **yes**, please answer **all** of the questions in section 4b and give details in section 6 of the form and enclose relevant hospital notes.

1. **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 5 years** ☐ Yes ☐ No

2. **Has the arrhythmia been controlled satisfactorily for at least 3 months?** ☐ Yes ☐ No

3. **Has an ICD or biventricular pacemaker (CRT-D type) been implanted?** ☐ Yes ☐ No

Signature

4. Has a pacemaker been implanted? ☐ Yes ☐ No If **yes**, please answer 4a - 4c.

a) Please give the date of implantation / /

b) Is the applicant free of the symptoms that caused the device to be fitted? ☐ Yes ☐ No

c) Does the applicant attend a pacemaker clinic regularly? ☐ Yes ☐ No

c Peripheral arterial disease (excluding Buerger's disease) aortic aneurysm/dissection

Is there a history of, or evidence of, peripheral arterial disease (excluding Buerger's disease), aortic aneurysm/dissection? ☐ Yes ☐ No

If **no,** please go to section 4d. If **yes**, please answer **all** of the questions in section 4c and give details in section 6 of the form and enclose relevant hospital notes.

1. Peripheral arterial disease (excluding Buerger's disease) ☐ Yes ☐ No

2. Does the applicant have claudication? ☐ Yes ☐ No

If **yes**, how long in minutes can the applicant walk at a brisk pace before being symptom-limited?

3. Aortic aneurysm? ☐ Yes ☐ No If **yes**, please answer 3a - 3c.

a) Where was the site of aneurysm? ☐ Thoracic ☐ Abdominal

b) Has it been repaired successfully? ☐ Yes ☐ No

c) Is the transverse diameter currently greater than 5.5cm? ☐ Yes ☐ No

If **no**, please provide the latest measurement and the date it was obtained / /

4. Dissection of the aorta repaired successfully? ☐ Yes ☐ No

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? ☐ Yes ☐ No

If **yes**, please provide relevant hospital notes.

d Valvular/congenital heart disease

Is there a history of, or evidence of, valvular/congenital heart disease? ☐ Yes ☐ No

If **no,** please go to section 4e. If **yes**, please answer **all** of the questions in section 4d and give details in section 6 of the form and enclose relevant hospital notes.

1. Is there a history of congenital heart disease? ☐ Yes ☐ No

2. Is there a history of heart valve disease? ☐ Yes ☐ No

3. Is there a history of aortic stenosis? ☐ Yes ☐ No

If **yes**, please provide relevant reports.

4. Is there any history of embolism? (not pulmonary embolism) ☐ Yes ☐ No

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5. **Does the applicant currently have significant symptoms?** ☐ Yes ☐ No

6. **Has there been any progression since the last licence application? (if relevant)** ☐ Yes ☐ No

e Cardiac other

Is there a history of, or evidence of, heart failure? ☐ Yes ☐ No

If **no**, please go to section 4f. If **yes**, please answer **all** of the questions in section 4e and give details in section 6 of the form and enclose relevant hospital notes.

1. **Established cardiomyopathy?** ☐ Yes ☐ No

2. **Has a left ventricular assist device (LVAD) been implanted?** ☐ Yes ☐ No

3. **A heart or heart/lung transplant?** ☐ Yes ☐ No

4. **Untreated atrial myxoma?** ☐ Yes ☐ No

f Cardiac investigations

Have any cardiac investigations been undertaken or planned? ☐ Yes ☐ No

If **no**, please go to section 4g. If **yes**, please answer **all** of the questions in section 4f and give details in section 6 of the form and enclose relevant hospital notes.

1. **Has a resting ECG been undertaken?** ☐ Yes ☐ No

If **yes**, does it show:

a) **pathological Q waves?** ☐ Yes ☐ No

b) **left bundle branch block?** ☐ Yes ☐ No

c) **right bundle branch block?** ☐ Yes ☐ No

If **yes** to a, b or c please provide a copy of the relevant ECG report or comment in section 6.

2. **Has an exercise ECG been undertaken (or planned)?** ☐ Yes ☐ No

a) **If yes, please give date** / /

Please provide relevant reports if available

3. **Has an echocardiogram been undertaken (or planned)?** ☐ Yes ☐ No

a) **If yes, please give date** / /

b) **If undertaken, is/was the left ejection fraction greater than or equal to 40%?** ☐ Yes ☐ No

Please provide relevant reports if available

4. **Has a coronary angiogram been undertaken (or planned)?** ☐ Yes ☐ No

a) **If yes, please give date** / /

Please provide relevant reports if available

Signature

5. **Has a 24 hour ECG tape been undertaken (or planned)?** ☐ Yes ☐ No

a) **If yes, please give date** / /

Please provide relevant reports if available

6. **Has a myocardial perfusion scan or stress echo study been undertaken (or planned)?** ☐ Yes ☐ No

a) **If yes, please give date** / /

Please provide relevant reports if available

g Blood pressure

If resting blood pressure is 180mm Hg systolic or more and/or 100mm Hg diastolic or more, please take a further two readings at least five minutes apart and record the best of the three readings in the box provided.

1. **Please record today's best blood pressure reading**

2. **Is the applicant on anti-hypertensive treatment?** ☐ Yes ☐ No

If yes, please provide three previous readings with dates if available.

	/ /
	/ /
	/ /

5 General

All questions must be answered. If yes to any of the questions in this section, please give full details in section 6.

1. **Is there currently any functional impairment that is likely to affect control of the vehicle?** ☐ Yes ☐ No

2. **Is there a history of bronchogenic carcinoma or other malignant tumour with a significant liability to metastasise cerebrally?** ☐ Yes ☐ No

3. **Is there any illness that may cause significant fatigue or cachexia that affects safe driving?** ☐ Yes ☐ No

4. **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. a textphone? ☐ Yes ☐ No

5. **Does the applicant have a history of liver disease of any origin?** ☐ Yes ☐ No

6. **Is there a history of renal failure?** ☐ Yes ☐ No

Signature

7. **Is there a history of, or evidence of, obstructive sleep apnoea syndrome or any other medical condition causing excessive sleepiness?** ☐ Yes ☐ No

If yes, please give a diagnosis

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. Please give details in section 6.

b) **Please answer questions i – vi for all sleep conditions.**

i) **Date of diagnosis** / /

ii) **Is it controlled successfully?** ☐ Yes ☐ No

iii) **If yes, please state treatment**

iv) **Is applicant compliant with treatment?** ☐ Yes ☐ No

v) **Please state period of control**

vi) **Date of last review** / /

8. **Does the applicant have severe symptomatic respiratory disease causing chronic hypoxia?** ☐ Yes ☐ No

9. **Does any medication currently taken cause the applicant side effects that could affect safe driving?** ☐ Yes ☐ No

10. **Does the applicant have any other medical condition that could affect safe driving?** ☐ Yes ☐ No

6 Further details

Please forward copies of relevant hospital notes. Please do not send any notes not related to fitness to drive. If there isn't enough space, please write "see note attached" and use a seperate sheet of headed paper.

7 Consultant's details

Signature

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

Consultant in

Name

Address

Consultant in

Name

Address

Consultant in

Name

Address

8 Medication

Please provide details of all current medication (continue on separate sheet if necessary).

Medication	Dosage
Reason for taking:	

Medication	Dosage
Reason for taking:	

Medication	Dosage
Reason for taking:	

Medication	Dosage
Reason for taking:	

9 Additional information

Patient's weight (kg)

Patient's height (cms)

Details of smoking habits (if any)

Units of alcohol taken each week

10 Examining doctor's details

To be completed by the doctor carrying out the examination. Please ensure all sections of the form have been completed. Failure to do so will result in the form being returned to you. Please print name and address in capital letters.

Name	
Address	
Phone number	
Fax	
Email address	

I confirm that this report was completed by me at examination and that I am currently GMC registered and licensed to practice in the UK or I am a doctor who is medically registered within the EU, if the report was completed outside of the UK.

Signature of practitioner	
Date of signature	/ /
GMC registration number	

Doctor's stamp

Applicant's consent and declaration

Signature

This section must be completed by the applicant.
Please read the following important information carefully and sign to confirm the statements below.

1 Data protection

Rushmoor Borough Council will use the information given in this medial form for the purpose of its statutory function(s) in its capacity as the relevant Licensing Authority in accordance with the provisions of the Local Government Miscellaneous Provisions Act 1976, the Town Police Clauses Act 1847 and the Public Health Act 1875.

You have the right to ask for a copy of the information we hold about you (for which we may charge a fee) and to correct any inaccuracies in your information. By returning this form to us you consent to our processing sensitive personal data about you where it is necessary, for example, criminal records.

2 Applicant declaration

I hereby consent to the Licensing Authority and the Medical Advisor of that Authority to receiving this report from my doctors and/or specialists about my medical condition and fitness to drive. I also acknowledge and consent that the Licensing Authority's Occupational Health/Medical Advisor may seek a medical report where it is deemed necessary subject to my continued consent and a summary explanation of my rights as per the Access to Medical Reports Act 1988. I understand that in such circumstances, I will be issued an Access to Medical Reports Act consent form with a summary of my rights. I further acknowledge that the Licensing Authority will only disclose such information as may be necessary to those involved in the determination of my application in accordance with the council's constitution and scheme of delegation. I also acknowledge the Data Protection notice given above and consent to the Licensing Authority to hold the information on this medical report for the purpose(s) stated.

Signature of applicant

Name of applicant
(in block capitals)

Date of signature / /