RUSHMOOR BOROUGH COUNCIL

MEDICAL ASSESSMENT

ASSOCIATED WITH AN APPLICATION FOR A LICENCE TO DRIVE A HACKNEY CARRIAGE OR PRIVATE HIRE VEHICLE

Notes for the Applicant

This medical examination now includes a vision assessment that must be filled in by a doctor or optician/optometrist. Some doctors will be able to fill in both vision and medical assessment section of the report. If your doctor is unable to fully answer all of the questions on the vision assessment you must have it filled in by an optician/optometrist. If you do not wear glasses to meet the eyesight test standard or if you have a minus (-) eyesight prescription, your doctor may be able to fill in the whole report. If you wear glasses and you have asked a doctor to fill in the report you must take your current prescription to the assessment.

The Council is not responsible for any fees that you may pay to a doctor and or optician/optometrist and or other medical specialist, even if you are unable to meet the Group 2 medical fitness to drive standard**.** Furthermore, if there are any medical issues detailed on your form, it will be referred to the Council's Medical Advisor, you will be required to cover the cost of this as a third-party fee. The fee will be payable before the referral is made.

You must take a form of photographic identity to the examination, for example your passport or DVLA driving licence

- All new driver applications are subject to a full Group II Medical Assessment completed by a GP at the surgery where the applicant is registered.
- Any driver renewing a licence is required to sign a self-declaration that nothing has changed.
- Any driver turning 45 is subject to a further medical, and then every 5 years thereafter until they reach the age of 65, then annually if they continue to hold a licence.

General

An applicant/driver with an on-going medical condition, i.e. diabetes, which is controlled by insulin, or has a heart condition, will be required to provide the Council with details of any change in that condition or in their medication.

During the life of a licence a driver diagnosed with a new medical condition or a driver who has an existing condition which develops is required to inform the Licensing Authority immediately. In these circumstances a further medical may be required. Failure to provide a medical assessment when due may lead to the suspension and/or refusal to renew a drivers licence. Applicants/drivers should ensure that they have allowed plenty of time to book GP appointment(s).

Applicant's details: (to be filled in the presence of the doctor carrying out the examination)

First name(s): Surname:	Date of birth: Age:	
Current address: **Post Code:** **Contact telephone number:**		

Applicant's consent and declaration:

(Please read the following carefully before signing and dating the declaration).

I authorise my General Practitioner(s) and Specialist(s) to release medical information about my condition, together with any relevant information relevant to fitness to drive, to the Taxi Licensing Section of Rushmoor Borough Council for the purpose of the Council (by its Officers and/or Members) of assessing my fitness to drive a hackney carriage or private hire vehicle licensed by that Council. The Licensing Authority may share this information with the Council's medical and legal advisers to determine an application, and with other sections of the Council to carry out its statutory functions. They may also share this information with outside bodies for the purposes of law enforcement or if the sharing is in the public interest. For full details of how the Council will handle any personal data we collect, please see our privacy policy at www.rushmoor.gov.uk/privacypolicy.

I declare that to the best of my knowledge and belief all information given by me to my doctors in connection with the examination or completion of the DVLA Group 2 medical examination report are true. In the event that the Council is not satisfied of my fitness to drive a hackney carriage or private hire vehicle.

I confirm that if I wish to do so, I may, at my own cost, submit further medical evidence to the Council as I consider appropriate.

Signed:	**Date:**

General Practitioner

This form must be completed in full by the applicant's own General Practitioner.
Please answer all questions and once completed sign the declaration at the end.

The Councils' policy on medical fitness requires that taxi drivers meet Group 2 Entitlement, as set out in the DVLA publication '*A Guide to the current Medical Standards of Fitness to Drive*'.

This guide makes reference to current best practice guidance contained in the booklet 'Fitness to Drive' which recommends the medical standard applied by DVLA in relation to bus and lorry drivers should also be applied by local authorities to taxi drivers.

(a)	**Is the applicant a registered patient of the surgery / medical centre at which you practice as a registered medical practitioner?**	**YES**	**NO***
(b)	**Have you reviewed the above applicant's medical records?** **If reviewing a printout of the medical records please give date of print out:**	**YES**	**NO**

***IF THE PATIENT IS NOT REGISTERED AT YOUR SURGERY AND YOU ARE REVIEWING A PRINTED HISTORY OF HIS/HER MEDICAL RECORDS – PLEASE ENCLOSE THE FULL COPY OF THE PRINTED HISTORY YOU HAVE SEEN, WITH THIS DOCUMENT.**

1	**Vision Assessment – to be completed by the GP or optician/optometrist** **Note: you must read the current DVLA guidance so that you can decide whether you are able to fully complete the vision assessment at** **www.gov.uk/current-medical-guidelines-dvla-guidance-for- professionals**					
	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. (Corrective lenses may be worn)**					
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**					
	Uncorrected		**Corrected (using the prescription worn for driving)**			
	Right	**Left**	**Right**	**Left**		
3.	**Please give the best binocular acuity with corrective lenses if worn for driving**					
4.	**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**
5.	**If a correction is worn for driving, is it well tolerated?**				**Yes**	**No**
6.	**Is there a history of any medical condition that may affect the applicant's binocular field of vision (central and /or peripheral)?** **If formal visual field testing**				**Yes**	**No**
	(c)	**Correction well tolerated?**			**Yes**	**No**
iii	**Please state the visual acuity of each eye**					
	Uncorrected		**Corrected (using the prescription worn for driving)**			
	Right	**Left**	**Right**	**Left**		
iv	**Is there a defect in the patient's binocular field of vision (central and/or peripheral)?**				**Yes**	**No**
v	**Is there diplopia (controlled or uncontrolled)?**				**Yes**	**No**
vi	**Does the patient have any other ophthalmic condition?** **If YES to questions 4, 5 or 6 please give details in Section 9.**				**Yes**	**No**
Any comments on the above:						
If eye examination has been completed by an optician/optometrist please give details below **Name:** **Address:** **Contact telephone number:**						

2	NERVOUS SYSTEM								
i	Has the patient had any form of epileptic attack? If YES, please answer questions a – f below							YES	NO
	(a)	Has the patient had more than one attack?						Yes	No
	(b)	Please give date of first and last attack:	First attack		Last attack				
	(c)	Is the patient currently on anti-epilepsy medication? If YES, please give details of current medication:						Yes	No
	(d)	If treated, please give date when treatment ended:							
	(e)	Has the patient had a brain scan? If YES, please state dates:						Yes	No
		MRI		CT					
	(f)	Has the patient had an EEG? If YES, please provide date and details						Yes	No
ii	Is there a history of blackout or impaired consciousness within the last 5 years? If YES, please give dates and details at Section 9.							Yes	No
iii	Is there a history of, or evidence of, any of the conditions listed at a – g below? If NO, go to Section 3.							Yes	No
	If YES, please answer the following questions and give dates and full details.								
	(a)	Stroke / TIA (*please delete as appropriate*) If YES, please give date:						Yes	No
		Has there been a full recovery?						Yes	No
	(b)	Sudden and disabling dizziness/vertigo within the last one year with a liability to recur						Yes	No
	©	Subarachnoid hemorrhage						Yes	No
	(d)	Serious head injury within the last 10 years						Yes	No
	(e)	Brain tumour, either benign or malignant, primary or secondary						Yes	No
	(f)	Other brain surgery/abnormality						Yes	No
	(g)	Chronic neurological disorders e.g. Parkinson's disease, Multiple Sclerosis						Yes	No
Any comments on the above:									

3		DIABETES MELLITUS		
i	Does the patient have diabetes mellitus? If NO, please go to Section 4. If YES, please FULLY COMPLETE SECTION 3.		Yes	No
ii	Is the diabetes managed by:			
	(a)	Insulin? If YES, please give date started on insulin AND CONFIRM THAT THE STANDARDS FOR INSULIN TREATED DRIVERS ARE MET – SEE BELOW (The licence application process cannot start until an applicant's condition has been stable for at least one month and they can provide two months of blood glucose readings whilst on insulin.)	Yes	No
	(b)	Exenatide/Byetta?	Yes	No
	(c)	Oral hypoglycaemic agents and diet? If YES, please provide details of medication:	Yes	No
	(d)	Diet only?	Yes	No
iii	Does the patient test blood glucose at least twice every day? (see note below)		Yes	No

For diabetics treated with INSULIN the following criteria must be met:
(There is a legal requirement for Group 2 drivers to monitor their blood glucose for the purpose of Group 2 driving. Flash GM and RT-CGM interstitial fluid glucose monitoring is not permitted for Group 2 driving and licensing. Group 2 drivers who use these devices must continue to monitor fingerprint capillary blood glucose levels with the regularity defined below.)

• practices blood glucose testing – at least twice daily, including days when not driving; and	Yes	No
• no more than 2 hours before the start of the first journey; and	Yes	No
• every 2 hours after driving has started	Yes	No
• A maximum of 2 hours between the pre-driving glucose test and the first glucose check performed after driving has started	Yes	No
• must use a blood glucose meter with sufficient memory to store three months of readings	Yes	No
• the applicant's usual doctor who provides diabetes care to undertake and examination at least every three years to include review of the previous three months glucose readings	Yes	No
• arranges an examination to be undertaken every 12 months by an independent consultant specialist in diabetes if the examination by their usual doctor is satisfactory (please attach latest report)	Yes	No
• full awareness of hypoglycaemia	Yes	No
• demonstrates an understanding of the risks of hypoglycaemia	Yes	No
• no episode of severe hypoglycaemia in the preceding 12 months	Yes	No
• has no disqualifying complications of diabetes that mean a licence will be refused or revoked, such as visual field defect	Yes	No

If the medical standards are met, a 1, 2 or 3 year licence may be issued.

For diabetics treated by medication other than insulin and carrying risks of hypoglycaemia the following criteria must be met:

• **full awareness of hypoglycaemia**	**Yes**	**No**
• **no episode of severe hypoglycaemia in the preceding 12 months**	**Yes**	**No**
• **practices regular self-monitoring of blood glucose– at least twice daily and at times relevant to driving (ie, no more than 2 hours before the start of the first journey and every 2 hours whilst driving)**	**Yes**	**No**
• **demonstrates an understanding of the risks of hypoglycaemia**	**Yes**	**No**
• **has no qualifying complications of diabetes that mean a licence will be refused or revoked, such as visual field defect**	**Yes**	**No**

If the medical standards are met, a 1, 2 or 3 year licence may be issued.

iv	**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**
	(c)	**Diminished / Absent awareness of hypoglycaemia?**	**Yes**	**No**
v	**Has there been any laser treatment for retinopathy? If YES, please give date(s) of treatment**		**Yes**	**No**
vi	**Is there a history of hypoglycaemia during waking hours in the last 12 months requiring assistance?**		**Yes**	**No**
	If YES to any of 4 – 6 above please give details in Section 9.			

Any comments on the above:

4	**PSYCHIATRIC ILLNESS**		
	Is there a history of, or evidence of any of the conditions listed at 1 – 7 below? If NO, please go to Section 5.	**YES**	**NO**
	If YES please answer the following questions and give date(s), prognosis, period of stability and details of medication, dosage and any side effects in Section 9. (Please enclose relevant notes - If patient remains under specialist clinic(s) and give full details in Section 9 especially if the applicant is on prescribed medication).		
i	**Psychiatric disorder within the past 6 months?**	**Yes**	**No**
ii	**A psychotic illness within the past 3 years, including psychotic depression?**	**Yes**	**No**
iii	**Dementia or cognitive impairment?**	**Yes**	**No**
iv	**Persistent alcohol misuse in the past 12 months?**	**Yes**	**No**
v	**Alcohol dependency in the past 3 years?**	**Yes**	**No**
vi	**Persistent drug misuse in the past 12 months?**	**Yes**	**No**
vii	**Drug dependency in the past 3 years?**	**Yes**	**No**
Any comments on the above:			
5	**CARDIAC * (Please read notes below)**		
	Is there a history of, or evidence of, Coronary Artery Disease? If NO, please go to Section 5B. If YES, please answer all questions below and give details at Section 9 of the form.	**YES**	**NO**
5A	**CORONARY ARTERY DISEASE**		
i	**Acute Coronary Syndromes including Myocardial Infarction? If YES please give date(s):**	**Yes**	**No**
ii	**Coronary artery by-pass graft surgery? If YES please give date(s):**	**Yes**	**No**
iii	**Coronary Angioplasty (P.C.I.)? If YES please give date of most recent intervention:**	**Yes**	**No**
iv	**Has the patient suffered from Angina? If YES please give the date of the last attack:**	**Yes**	**No**
*** If a patient has established coronary heart disease evidence is required in the form of an exercise ECG, or stress myocardial profusion scan/stress echocardiogram. These tests must be completed every three years in accordance with Appendix C, Assessing fitness to drive. A guide for medical professionals. Please see https://www.gov.uk/government/publications/assessing-fitness-to-drive-a-guide-for-medical-professionals Applicants/Drivers cannot meet the requirements without these tests.**			
Any comments on the above:			
Please go to next Section 5B			

5B	CARDIAC ARRHYTHMIA		
	Is there a history of, or evidence of, cardiac arrhythmia? **If NO, go to Section 5C.** **If YES, please answer all questions below and give details in Section 9.**	**YES**	**NO**
i	**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 last 5 years?**	**Yes**	**No**
ii	**Has the arrhythmia been controlled satisfactorily for at least 3 months?**	**Yes**	**No**
iii	**Has an ICD or biventricular pacemaker (CRST-D type) been implanted?**	**Yes**	**No**
iv	**Has a pacemaker been implanted? If YES:**	**Yes**	**No**
	(a) Please supply date:		
	(b) Is the patient free of symptoms that caused the device to be fitted?	**Yes**	**No**
	(c) Does the patient attend a pacemaker clinic regularly?	**Yes**	**No**
Any comments on the above:			
Please go to next Section 5C			

5C	PERIPHERAL ARTERIAL DISEASE (EXCLUDING BUERGER'S DISEASE) AORTIC ANEURYSM/DISSECTION					
	Is there a history or evidence of ANY of the following? If NO go to Section 5D. **If YES please answer the questions below and give details in Section 9.**				**YES**	**NO**
i	**Peripheral Arterial Disease (excluding Buerger's Disease)**				**Yes**	**No**
ii	**Does the patient have claudication?** **If YES please give details as to how long in minutes the patient can walk at a brisk pace before being symptom limited:**				**Yes**	**No**
iii	**Aortic aneurysm? YES:** **Note: the exercise or other functional test requirements will need to be met in all cases of abdominal aortic aneurysm irrespective of the diameter**					
	(a)	**Site of Aneurysm (please tick):**	**Thoracic** ☐	**Abdominal** ☐		
	(b)	**Has it been repaired successfully?**			**Yes**	**No**
	(c)	**Is the transverse diameter currently >5.5 cms?**			**Yes**	**No**
		If NO, please provide latest measurement:		**Date obtained:**		
iv	**Dissection of the aorta repaired successfully?** **If YES, please provide details**				**Yes**	**No**

Any comments on the above:
Please go to next Section 5D

5D	VALVULAR/CONGENITAL HEART DISEASE		
	Is there a history of, or evidence of, valvular/congenital heart disease?	Yes	No
	If NO, go to Section 5E. If YES, please answer all questions below and give details in Section 9 of the form		
i	Is there a history of congenital heart disorder?	Yes	No
ii	Is there a history of heart valve disease?	Yes	No
iii	Is there any history of embolism? (not pulmonary embolism)	Yes	No
iv	Does the patient currently have significant symptoms?	Yes	No
v	Is there a history of, aortic stenosis? If Yes, please provide relevant reports.	Yes	No
vi	Has there been any progression since the last licence application? (if relevant)	Yes	No
Any comments on the above:			

5E	CARDIAC OTHER			
	Does the patient have a history of ANY of the following conditions? If NO go to Section 5F If YES please answer all questions below and give details in Section 9 of the form		YES	NO
	(a)	A history of, or evidence of, heart failure?	Yes	No
	(b)	Established cardiomyopathy?	Yes	No
	(c)	A heart or heart/lung transplant?	Yes	No
	(d)	Has a left ventricular assist device (LVAD) been implanted?	Yes	No
Any comments on the above:				

5F	CARDIAC INVESTIGATIONS (This section must be filled in for all patients)			
i	Has a resting ECG been undertaken? If YES, does it show:		YES	NO
	(a)	Pathological Q waves?	Yes	No
	(b)	Left bundle branch block?	Yes	No
	(c)	Right bundle branch block?	Yes	No
ii	Has the exercise ECG been undertaken (or planned)?		Yes	No
	If YES please provide date and give details in Section 9:			
iii	Has an echocardiogram been undertaken (or planned)?		Yes	No
	(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%?	Yes	No
iv		Has a coronary angiogram been undertaken (or planned)? If YES, please provide date and give details in Section 9:	Yes	No

v		**Has a 24 hour ECG tape been undertaken (or planned)? If YES, please provide date and give details in Section 9:**	**Yes**	**No**
vi		**Has a Myocardial Perfusion Scan or Stress Echo study been undertaken (or planned)? If YES, please provide date and give details in Section 9:**	**Yes**	**No**

Any comments on the above:

Please go to next Section 5G

5G	**BLOOD PRESSURE (This section must be filled in for all patients)**		
i	**Is today's best systolic pressure reading 180 mm/Hg or more? (Please give reading) BP reading:**	**Yes**	**No**
ii	**Is today's best diastolic pressure reading 100mm Hg or more? (Please give reading) BP reading:**	**Yes**	**No**
iii	**Is the patient on anti-hypertensive treatment?**	**Yes**	**No**
	If YES to any of the above please provide three previous readings with dates if available:		
	1. B.P reading:	**Date:**	
	2. B.P reading:	**Date:**	
	3. B.P reading:	**Date:**	

Any comments on the above:

6.	GENERAL Please answer all questions in this section. If your answer is YES to any question please give full details in Section 9.				
i	Is there currently a disability of the spine or limbs likely to impair control of the vehicle?			Yes	No
ii	Is there a history of bronchogenic carcinoma or other malignant tumour, for example, malignant melanoma, with a significant liability to metastasise?			Yes	No
	If YES please give dates and diagnosis and state whether there is current evidence of dissemination?				
	(a)	Is there any evidence the patient has a cancer that causes fatigue or cachexia that affects safe driving?		Yes	No
iii	Is the patient profoundly deaf?			Yes	No
	If YES is the patient able to communicate in the event of an emergency by speech or by using a device e.g. a text/phone?			Yes	No
iv	Is there a history of either renal or hepatic failure?			Yes	No
v	Is there a history of, or evidence of sleep apnoea syndrome?			Yes	No
	If YES please indicate severity Mild (AHI <15) ☐ Moderate (AHI 15 – 29) ☐ Severe (AHI >29) ☐ Not known ☐				
	(a)	Date of diagnosis:			
	(b)	Is it controlled successfully?		Yes	No
	(c)	If YES please state treatment:	(d) Please state period of control:		
	(e)	Please provide neck circumference:			
	(f)	Please provide girth measurement in cms			
	(g)	Date last seen by consultant:			
vi	Does the patient suffer from narcolepsy/cataplexy?			Yes	No
vii	Is there any other Medical Condition causing daytime sleepiness?			Yes	No
	If YES please provide details:				
	(a)	Diagnosis:			
	(b)	Date of diagnosis:			
	(c)	Is it controlled successfully?		Yes	No
	(d)	If YES please state treatment:	(e) Please state period of control:		
	(f)	Date last seen by consultant:			
viii	Does the patient have severe symptomatic respiratory disease causing chronic hypoxia?			Yes	No
ix	Does any medication currently taken cause the patient side effects that could affect safe driving?			Yes	No
	If YES please provide details:				
x	Does the patient have any other medical condition that could affect safe driving?			Yes	No
	If YES please provide details:				
Any comments on the above:					

7.	**ALCOHOL AND/OR DRUG MIS-USE** **Please answer all questions in this section.** **If your answer is YES to any question please give full details in Section 9.**		
i	**Does the patient show any evidence of being addicted to the excessive use of alcohol?**	**Yes**	**No**
ii	**Does the patient show any evidence of being addicted to the excessive use of drugs?**	**Yes**	**No**
Any comments on the above:			
8.	**EQUALITIES ACT 2010** **Please answer all questions in this section.** **If your answer is YES to any question please give full details in Section 9 and include copies of any relevant medical reports.**		
i	**Does the patient have any medical or any physical condition that makes it impossible or unreasonably difficult for them to load or unload a passenger seated in a wheelchair into a vehicle, load a wheelchair into the boot of a vehicle or give reasonable assistance to a disabled passenger?**	**Yes**	**No**
ii	**Does the patient have any medical condition that requires an exemption from carrying guide dogs, hearing dogs or other assistance dogs?**	**Yes**	**No**
9.	**Additional Information**		

General Practitioner

DECLARATION: Please read the following carefully before completing, signing and dating the declaration.

If the applicant/patient is not a registered patient with your practice or you have not reviewed his/her medical records then do not complete the declaration.

I certify that I have reviewed the applicant's medical records and that in my opinion nothing therein contradicts or tends to contradict the information given to me by the applicant.

I certify that I have today undertaken a medical examination of the applicant for the purpose of assessing their fitness to act as a driver of a Hackney Carriage or Private Hire driver under the DVLA Group 2 medical standards

<table>
<tr><td>Doctor's name:</td><td rowspan="3">Surgery Stamp:
(not accepted without surgery stamp)</td></tr>
<tr><td>Surgery name:</td></tr>
<tr><td>Surgery address:</td></tr>
<tr><td>Signed:</td><td>Date:</td></tr>
</table>