



Hackney Carriage Medical Form

Group II Medical Examination Report

| | |
|-----------------------------|-------|
| Checked by: | Date: |
| Licence/application number: | |



Making Swale a better place

Taxi Licencing

taxis@swale.gov.uk

Licensing Team

Swale House, East Street

Sittingbourne ME10 3HT

Group II Medical Examination Report Form

Information Notes

It is a requirement under Section 57 of the Local Government (Miscellaneous Provisions) Act 1976 to provide a Medical Examination Report to the effect that you are physically fit to drive a Public, Private Hire or Contract vehicle.

This form is to be completed by the applicant's own General Practitioner (GP) or another GP within the same practice, or a GP at another practices, provided they have access to the applicant's full NHS records at the time of the examination.

Drivers are required to complete a Group II Medical Report Form every three years, until the age of 70, when an annual form is required.

*there are certain medical conditions that require an annual medical report.

Any fee charged is payable by the applicant.

- Please complete this form – alternative forms will not normally be accepted.
- Please complete in block capitals using black ink.

Applicants must take a form of photographic identity to the examination, eg. your passport or DVLA driving licence.

Licensing officers are not permitted to complete or amend forms on behalf of applicants for legal reasons.

Guidance notes

What you have to do:

1. In assessing an individual's medical fitness, Swale Council has decided to be guided by the DVLA Group 2 standards.
2. If, after reading the notes, you have any doubts about your ability to meet the medical or eyesight standards, consult your GP/ Optician before you arrange for this medical form to be completed, as your GP will normally charge you for completing it. In the event of your application being refused, the fee you pay your GP is not refundable. Swale Borough Council has no responsibility for the fee payable to your GP.
3. Fill in Section 8 of this report in the presence of the GP carrying out the examination.
4. A delay in submitting your Group II Medical Report Form (once required) may delay the processing of your application.
5. Provide a current passport size photo to the GP at the time of examination.

What the GP has to do:

1. Medical practitioners are asked to confirm that the applicant complies with the Group 2 medical standards, set by the Driver and Vehicle Licensing Agency (DVLA). Read the DVLA medical standards for a summary at:
www.gov.uk/government/publications/assessing-fitness-to-drive-a-guide-for-medical-professionals.
2. Arrange for the patient to be seen and examined. (GPs must ensure the identity of the individual they are carrying out the examination on.)
3. Applicants who may be asymptomatic at the time of the examination should be advised that, if in future they develop symptoms of a condition that could affect safe driving and they hold either a Hackney Carriage and/or Private Hire driver licence, they must inform the Taxi Licencing Section (email: taxis@swale.gov.uk).
4. Please ensure that you have completed all sections required within this form. If this report does not bring out important clinical details with respect to driving, please give details in Section 6.
5. Sign to verify that the photo is a true reflection of the applicant who attended the medical examination.

This page must be completed by the applicant.

Your details:

To be completed in BLOCK CAPITAL LETTERS, one letter to each box only, with a space between your first/middle names and surname

Your full name (surname last):

Address:

Postcode:

Date of birth:

Email address:

Daytime telephone number

Your doctor's details:

Name of doctor or GP practice:

Address:

Postcode:

Email address:

Daytime telephone number:

Vision assessment – to be completed by your optician/optometrist

If correction is needed to meet the eyesight standard for driving, all questions must be answered. If correction is not needed, questions 5 and 6 can be ignored.

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 the prescription worn for driving) | |
|-------------|---|---|---|
| L | R | L | R |
| | | | |

3. Is the visual acuity at least 6/7.5 in the better eye and as least 6/60 in the other eye? (Corrective lenses may be worn to meet this standard.)

Yes No

7. 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 is considered necessary, DVLA will commission this at a later date.

Yes No

4. Were corrective lenses worn to meet the standard?

Yes No

If Yes,

glasses contact lenses both together

8. Is there diplopia?

If yes, please provide full details in box provided.

Yes No

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

9. When questioned, does the applicant report symptoms of intolerance to glare and/or impaired contrast to sensitivity and/or impaired twilight vision?

Yes No

6. If a correction is worn for driving, is it well tolerated?
If No, please provide details in the box provided.

Yes No

10. Does the applicant have any other ophthalmic condition?
If Yes, please give details in box provided.

Yes No

| | |
|-----------------------------|---|
| Details/additional comments | Name of examining doctor/optician (print) |
| | Signature of examining doctor/optician |
| | Date of signature: |
| | Please provide your GOC, HPC or GMC number. |
| | _____ |
| | Doctor's/optometrist's/optician's stamp |

Section 1. Nervous system – to be completed by your GP

1. Has the patient had any form of epileptic attack? If Yes, please answer all questions below and supply reports if available.

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 applicant currently on anti-epileptic medication? If Yes, please give details of current medication in Section 6.

Yes No

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

(e) Has the patient had a brain scan? If Yes, please give details in Section 6.

Yes No

(f) Has the patient had an EEG?

Yes No

2. Is there any history of stroke or TIA? If yes, please give date.

Yes No

Has there been a full recovery?

Yes No

Has a carotid ultrasound taken place?

Yes No

3. Has there been sudden and disabling dizziness/vertigo within the past one year with a liability to recur?

Yes No

7. Other brain surgery or abnormality

Yes No

4. Subarachnoid haemorrhage

Yes No

8. Chronic neurological disorder

Yes No

5. Serious traumatic brain injury within the past ten years

Yes No

9. Parkinson's disease

Yes No

6. Any form of brain tumour

Yes No

10. Is there any history of blackout or impaired consciousness within the past five years? If Yes, please give dates and details in Section 6.

Yes No

Section 2. Diabetes mellitus

1. Does the patient have diabetes mellitus? If Yes, please answer all the following questions.

Yes No

(a) Is the diabetes managed by Insulin?

Yes No If Yes, please give date started on insulin: **DD / MM / YYYY**

(b) If treated with insulin, are there at least three months of blood glucose readings stored on a memory meter? If No, please give details in Section 6.

Yes No

(c) Are there other injectable treatments?

Yes No

(d) Is there a Sulphonylurea or a Glinide?

Yes No

(e) Oral hypoglycaemic agents or diet?

Yes No

(f) Diet only?

Yes No

2. (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

3. Is there any evidence of impaired awareness of hypoglycaemia?

Yes No

4. Is there a history of hypoglycaemia in the past 12 months requiring the assistance of another person? If Yes, please give details in Section 6.

Yes No

5. (a) Is there evidence of: Loss of visual field? If Yes, please give details in Section 6.

Yes No

(b) Severe peripheral neuropathy, sufficient to impair limb function for safe driving?

If Yes, please give details in Section 6.

Yes No

6. Has there been any laser treatment or intravitreal treatment for retinopathy?

If Yes, please give details in Section 6.

Yes No If Yes, please give date(s) of treatment: **DD / MM / YYYY**

Section 3. Psychiatric illness

Is there a history of or evidence of psychiatric illness or drug/alcohol misuse within the past three years? If Yes, please answer all the questions. Please provide full details in Section 6, including dates, period of stability and, where appropriate, consumption and frequency of use. If No, please go to Section 4.

Yes No

1. Has there been significant psychiatric disorder within the past six months?

Yes No

2. Has there been psychosis or hypomania/mania within the past 12 months, including psychotic depression?

Yes No

3. Has there been dementia or cognitive impairment?

Yes No

4. Has there been persistent alcohol misuse in the past 12 months?

Yes No

5. Has there been alcohol dependency in the past three years?

Yes No

6. Has there been persistent drug misuse in the past 12 months?

Yes No

7. Has there been drug dependency in the past three years?

Yes No

Section 4. Cardiac

Section 4A coronary artery disease

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

If Yes, please answer all questions below and give details at Section 6, enclosing relevant hospital notes.

If No, please go to Section 4B.

Yes No

1. Has the applicant ever suffered from angina?

Yes No If Yes, please give date: **DD / MM / YYYY**

2. Has there been acute coronary syndrome, including myocardial infarction?

Yes No If Yes, please give date: **DD / MM / YYYY**

3. Has there been coronary angioplasty (PCI)?

Yes No If Yes, please give date of the most recent intervention: **DD / MM / YYYY**

4. Has there been coronary artery bypass graft surgery?

Yes No If Yes, please give date: **DD / MM / YYYY**

Section 4B Cardiac arrhythmia

Is there a history or evidence of cardiac arrhythmia

If Yes, please answer the questions below and give details in Section 6.

If No, go to Section 4C.

Yes No

1. Has there been a significant disturbance of cardiac rhythm (ie. sinoatrial disease, significant atrioventricular conduction defect, atrial flutter/fibrillation, narrow or broad complex tachycardia) in the past five years?

Yes No

2. Has the arrhythmia been controlled satisfactorily for at least three months?

Yes No

3. Has an ICD or biventricular pacemaker (CRST-D type) been implanted?

Yes No

4. Has a pacemaker been implanted?

Yes No

If Yes:

(a) Please give date: **DD / MM / YYYY**

(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

Section 4C Peripheral Arterial Disease

Is there a history or evidence of peripheral arterial disease (excluding Buerger's disease aortic aneurysm/dissection)?

If Yes, please answer the questions below and give details in Section 6 enclosing any relevant hospital notes.

If No, go to Section 4D.

Yes No

1. Peripheral Arterial Disease (excluding Buerger's disease)

Yes No

2. Does the patient have claudication?

Yes No

If Yes, please say how long in minutes the patient can walk at a brisk pace before being symptom-limited:

3. Aortic aneurysm

Yes No

If Yes:

(a) Site of aneurysm (please tick)

Thoracic Abdominal

(b) Has it been repaired successfully?

Yes No

(c) Is the transverse diameter currently >5.5cms?

Yes No

If No, please provide latest measurement:

Date obtained: **DD / MM / YYYY**

4. Dissection of the aorta repaired successfully?
If Yes, please provide copies of all reports to include those dealing with any surgical treatment.
Yes No

5. Is there a history of Marfan syndrome?
If Yes, please provide relevant hospital notes.
Yes No

Section 4D Valvular/congenital heart disease
Is there a history of or evidence of valvular/congenital heart disease?
If Yes, please answer all questions below and give details in Section 8 of the form. If No, go to Section 4E.
Yes No

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? If Yes, please provide relevant reports.
Yes No

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

5. Does the patient currently have significant symptoms?
Yes No

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

Section 4E Cardiac other
Is there a history of or evidence of heart failure? If Yes, please answer all questions below. If No, go to Section 4F
Yes No

1. Established cardiomyopathy?
Yes No

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

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

4. Untreated atrial myxoma
Yes No

Section 4F Cardiac Investigations

1. Have any cardiac investigations been undertaken or planned? If No, go to Section 4G. If Yes, please answer all questions
Yes No
(a) Pathological Q waves?
Yes No
(b) Left bundle branch block?
Yes No
(c) Right bundle branch block?
Yes No

2. Has the exercise ECG been undertaken (or planned)?
Yes No If Yes, please give date and give details in Section 6. **DD / MM / YYYY**

3. Has an echocardiogram been undertaken (or planned)?
Yes No
(a) If Yes, please give date and give details in Section 6. **DD / MM / YYYY**
(b) If undertaken, is/was the left ejection fraction greater than or equal to 40%?
Yes No

4. Has a coronary angiogram been undertaken (or planned)?
Yes No If Yes, please provide date and give details in Section 8. **DD / MM / YYYY**

5. Has a 24-hour ECG tape been undertaken (or planned)?
Yes No If Yes, please provide date and give details in Section 8. **DD / MM / YYYY**

6. Has a Myocardial Perfusion Scan or Stress Echo study been undertaken (or planned)?
Yes No If Yes, please provide date and give details in Section 8. **DD / MM / YYYY**

Section 4G Blood pressure
This section must be filled in for all patients

If the blood pressure is 180/100mmHg systolic or more and/or 100mmHg 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 patient on antihypertensive treatment?
Yes No

If Yes to any of the above, please provide three previous readings with dates if available:

1. Blood pressure reading: Date: **DD / MM / YYYY**
2. Blood pressure reading: Date: **DD / MM / YYYY**
3. Blood pressure reading: Date: **DD / MM / YYYY**

Section 5. General

All questions must be answered. If your answer is Yes to any question, 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 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, eg. a textphone?

Yes No

5. Is there a history of liver disease of any origin? If Yes, please give details in Section 6.

Yes No

6. Is there a history of renal failure? If Yes, please give details in Section 6.

Yes No

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 diagnosis.

(a) If Obstructive sleep apnoea syndrome, please indicate severity:

Mild (AHI 15) Moderate (AHI 15–29) Severe (AHI >29) Unknown

If another measurement other than AHI is used, it must be one that is recognised by clinical practice as equivalent to AHI. DVLA does not prescribe different measurements, as this is a clinical issue. Please give details in Section 6.

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

i Date of diagnosis: **DD / MM / YYYY**

ii Is it controlled successfully? Yes No

iii If Yes, please state treatment:

iv Is the applicant compliant with treatment? Yes No

v Please state period of control:

vi Date of last review: **DD / MM / YYYY**

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? If Yes, please provide details of medication and symptoms in Section 6.

Yes No

10. Does the applicant have an ophthalmic condition? If Yes, please provide details in Section 6.

Yes No

11. Does the patient have any other medical condition that could affect safe driving?

If Yes, please provide details in Section 6.

Yes No

12. Do you consider the applicant unable to load/unload a wheelchair bound passenger without assistance?

Yes No

13. Does the applicant have any allergies to dogs?

Yes No

Section 6 Further Details

Please provide section/question numbers the notes refer to – use additional sheets if required and attach only documents that relate to fitness to drive.

| Section 7. Consultant details | |
|---|---|
| Consultant in: | Consultant in: |
| Name: | Name: |
| Address: | Address: |
| Date of last appointment: DD / MM / YYYY | Date of last appointment: DD / MM / YYYY |
| Consultant in: | Consultant in: |
| Name: | Name: |
| Address: | Address: |
| Date of last appointment: DD / MM / YYYY | Date of last appointment: DD / MM / YYYY |

| Section 8. Medication | |
|--|--------------------|
| Details of all current medication (continue on separate sheet if necessary). | |
| Medication: | Medication: |
| Dosage: | Dosage: |
| Reason for taking: | Reason for taking: |
| Medication: | Medication: |
| Dosage: | Dosage: |
| Reason for taking: | Reason for taking: |
| Medication: | Medication: |
| Dosage: | Dosage: |
| Reason for taking: | Reason for taking: |

| Section 9. Additional information | |
|--|-------------------------|
| Applicant's weight (kg) | Applicant's weight (kg) |
| Height (cms) | Height (cms) |

Section 10. Examining doctor's details

To be completed by the doctor carrying out the examination.
Please ensure that all sections of the form (including the declaration) have been completed.
Failure to do so will result in the form being sent back to you.

Name:

Address:

Telephone:

Fax:

email:

Applicant – consent and declaration

This section must be completed by the applicant and must not be altered in any way.

Important information about consent

Swale Borough Council may in certain circumstances, as part of its assessment of your fitness to drive a hackney carriage or private hire vehicle, require additional information about your medical fitness.

I declare that I have checked the details I have given on the enclosed medical report form, and that to the best of my knowledge and belief they are correct.

I understand that it is a criminal offence if I make a false declaration to obtain a hackney carriage or private hire driver licence.

I authorise my doctor(s) and specialist(s) to release reports to Swale Borough Council Licensing Section about my medical condition if necessary*. I declare that I have checked the details I have given on the enclosed questionnaire and that to the best of my knowledge they are correct.

I authorise Swale Borough Council Licensing Section to release medical information to my doctor(s) and/or specialist(s) about the outcome of my case. (This is to enable your doctor to advise you about your fitness to drive.)

Signature:

Date: DD / MM / YYYY

Note about consent

*The Council will only ask for release of medical reports if required, ie. where an application needs to be determined at a hearing on medical grounds.

The Council will never under any circumstances release information that is not relevant to fitness to drive, nor would we expect to receive this from your doctor(s).

We hope you will find this helpful and reassuring and will return the signed consent.

General Practitioner declaration

I certify that I am the named applicant's General Practitioner or a General Practitioner with full access to the applicant's NHS records at the time of the examination.

I certify that I have reviewed all the applicant's medical history and have today examined the named applicant's ability to act as a licensed driver in the Borough of Swale.

I declare that the answers to all questions are true to the best of my knowledge and belief.

I understand that it is an offence for the person completing this form to make a false statement or omit relevant details.

Please tick as appropriate:

- I consider the applicant fit to operate a licensed vehicle.
- I consider the applicant unfit to operate a licensed vehicle.

Name:

Signature:

Date: **DD / MM / YYYY**

GP's practice stamp: