canterbury city council

Medical examination report

for taxi and private hire drivers

Your details (applicant)

Name			
Full address			
Daytime phone number		Date of birth	
Email address			

Your doctor's details

Doctor's name	
Full address	
Phone number	
Email address	

You must sign and date the declaration on page 8 when the doctor and/or optician has completed the report.

Examining doctor's details - to be completed by the doctor carrying out the examination.

Doctor's name	
Full address	
Phone number	
Email address	
GMC registration number	

You must sign and date this form in Section 10. All black outlined boxes MUST be answered. Please make sure all sections of the form have been completed. The form will be returned to you if you don't do this.

Vision assessment

To be filled in by a doctor or 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 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, 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? **Yes** ☐ **No** ☐
If **No**, please give full 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? ☐ ☐

If **Yes**, please give full details in the box provided

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** ☐

If **Yes** to any of questions 7 to 10, please give full details in the box provided.

Details/additional information

You must sign and date this section.

Name of examining doctor/optician (print)

Signature of examining doctor/optician

Date of signature D D M M Y Y

Please provide your GOC, HPC or GMC number

Doctor/optometrist/optician's stamp

Applicants full name _____ Date of birth D D M M Y Y

Please do not detached this page

Medical assessment

Must be filled in by a doctor

Please check the applicant's identity before you proceed.

Please ensure you fully examine the applicant and take the applicant's history.

1 Neurological disorders

Please tick (✓) the appropriate box(es)

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

If **No**, go to section 2

If **Yes**, please answer **all** the questions below, give details in section 6, page 6 and enclose relevant hospital notes.

	Yes	No
1. Has the applicant had any form of seizure?	☐	☐
(a) Has the applicant had more than one attack?	☐	☐
(b) Please give date of first and last attack		
First attack D D M M Y Y		
Last attack D D M M Y Y		
(c) Is the applicant currently on anti-epileptic medication?	☐	☐
If **Yes,** please fill in current medication in **section 8, page 7**		
(d) If no longer treated, please give date when treatment ended D D M M Y		
(e) Has the applicant had a brain scan? If **Yes,** please give details in **section 6, page 6**	☐	☐
(f) Has the applicant had an EEG? If **Yes** to any of above, please supply reports if available.	☐	☐
2. Stroke or TIA?	☐	☐
If **Yes**, please give date D D M M Y		
Has there been a **FULL** recovery?	☐	☐
Has a carotid ultra sound been undertaken?	☐	☐
If **Yes**, was the carotid artery stenosis >50% in either carotid artery?	☐	☐
Has there been a carotid endarterectomy?	☐	☐
3. Sudden and disabling dizziness/vertigo within the last year with a liability to recur?	☐	☐
4. Subarachnoid haemorrhage?	☐	☐
5. Serious traumatic brain injury within the last 10 years?	☐	☐
6. Any form of brain tumour?	☐	☐
7. Other brain surgery or abnormality?	☐	☐
8. Chronic neurological disorders?	☐	☐
9. Parkinson's disease	☐	☐
10. Is there a history of blackout or impaired consciousness within the last five years?	☐	☐
11. Does the applicant suffer from narcolepsy?	☐	☐

2 Diabetes mellitus

	Yes	No
Does the applicant have diabetes mellitus?	☐	☐

If **No**, go to section 3, page 4

If **Yes**, please answer all the questions below.

	Yes	No
1. Is the diabetes managed by:		
(a) Insulin?	☐	☐
If **Yes**, please give date started on insulin D D M M Y		
(b) If treated with insulin, are there at least three continuous months of blood glucose readings stored on a memory meter(s)?	☐	☐
If **No**, please give details in **section 6, page 6**		
(c) Other injectable treatments?	☐	☐
(d) A Sulphonylurea or a Glinide?	☐	☐
(e) Oral hypoglycaemic agents and diet?	☐	☐
If **Yes** to any of (a)-(e), please fill in current medication in **section 8, page 7**		
(f) Diet only?	☐	☐
2. (a) Does the applicant test blood glucose at least twice every day?	☐	☐
(b) Does the applicant test at times relevant to driving (no more than two hours before the start of the first journey and every two hours while driving)?	☐	☐
(c) Does the applicant keep fast acting carbohydrate within easy reach when driving?	☐	☐
(d) Does the applicant have a clear understanding of diabetes and the necessary precautions for safe driving?	☐	☐
3. Is there any evidence of impaired awareness of hypoglycaemia?	☐	☐
4. Is there a history of hypoglycaemia in the last 12 months requiring the assistance of another person	☐	☐
5. Is there evidence of:		
(a) Loss of visual field?	☐	☐
(b) Severe peripheral neuropathy, sufficient to impair limb function for safe driving?	☐	☐
If **Yes** to any of 4-5 above, please give details in **section 6, page 6**		
6. Has there been laser treatment or intra-vitreal treatment for retinopathy?	☐	☐

If **Yes**, please give date(s) of treatment.

Applicants full name _____ Date of birth D D M M Y Y

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**, go to **section 4**

If **Yes**, please answer all questions below

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** ☐

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 questions above, please provide full details in section 6, page 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**, go to **section 4b**

If **Yes**, please answer all questions below and give details in **section 6 page 6**, and enclose relevant hospital notes.

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

If **Yes**, please give the dateof the last known attack D D M M Y

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

If **Yes**, please give the date D D M M Y

3. Coronary angioplasty (PCI.)? **Yes** ☐ **No** ☐

If **Yes**, please give date of most recent intervention D D M M Y

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

If **Yes**, please give date D D M M Y

5. If **Yes** to any of the above, are there any physical health problems (e.g. mobility/ arthritis, COPD) that would make the applicant unableto undertake nine minutes of the standard Bruce Protocol ETT? **Yes** ☐ **No** ☐

b Cardiac arrhythmia

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

If **No**, go to **section 4c**

If **Yes**, please answer all questions below and give details in **section 6, page 6** and enclose relevant hospital notes.

1. Has there been a **significant** disturbance of cardiac rhythm, ie sinoatrial disease, significant atrio-ventricular conduction defect, atrial flutter/fibrillation, narrow or broad complex tachycardia in the last 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 (CRT-D type) been implanted? **Yes** ☐ **No** ☐

4. Has a pacemaker been implanted? **Yes** ☐ **No** ☐

If **Yes**:

(a) Please give date of implantation D D M M Y Y

(b) Is the applicant free of the symptoms that caused the device to be fitted? ☐ ☐

(c) Does the applicant attend a pacemaker clinic regularly? ☐ ☐

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**, go to **section 4d**

If **Yes**, please answer all questions below and give details at **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?

Please give details

3. Aortic aneurysm? **Yes** ☐ **No** ☐

If **Yes**:

(a) Site of aneurysm: Thoracic ☐ Abdominal ☐

(b) Has it been repaired successfully? ☐ ☐

(c) Is the transverse diameter currently >5.5 cm? ☐ ☐

If **No**, please provide latest measurement and date 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

Applicants full name _____ Date of birth D D M M Y Y

d Valvular/congenital heart disease

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

If **No**, go to section 4e

If **Yes**, please answer all questions below and give details in **section 6 page 6** 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** ☐

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**, go to section 4f

If **Yes**, please answer all questions 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 Blood pressure

If resting blood pressure is 180 mm/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 resting** blood pressure reading

2. Is the applicant on anti-hypertensive treatment?

If Yes, please provide three previous readings with dates if available

	D D M M Y Y
	D D M M Y Y
	D D M M Y Y

g Cardiac investigations

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

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

If **Yes**, please answer all questions **Yes** **No**

1. Has a resting ECG been undertaken? ☐ ☐

   If **Yes**, does it show:

   (a) pathological Q waves?

   (b) left bundle branch block?

   (c) right bundle branch block?

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

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

If **Yes**, please give date and give details in **section 6, page 6**

Please provide relevant reports if available

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

(a) If **Yes**, please give date and give details in **section 6, page 6**. D D M M Y Y

(b) If undertaken, is/was the left ejection fraction greater than or equal to 40%? ☐ ☐

Please provide relevant reports if available

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

If **Yes**, please give date and give details in **section 6, page 6**. D D M M Y Y

Please provide relevant reports if available

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

If **Yes**, please give date and give details in **section 6, page 6**. D D M M Y Y

Please provide relevant reports if available

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

If **Yes**, please give date and give details in **section 6, page 6**. D D M M Y Y

Please provide relevant reports if available

5 General

All questions must be answered. If **Yes** to any, give full details in section 6 and enclose relevant hospital notes.

1. 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 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 D D M M Y Y

(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 D D M M Y Y

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

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

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

5. 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, eg a textphone? ☐ ☐

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

If **Yes**, please give details in **section 6**

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

If **Yes**, please give details in **section 6**

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** ☐

If **Yes**, please provide details of medication and symptoms in **section 6**

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

If **Yes**, please provide details in **section 6**

6 Further details

Please forward copies of relevant hospital notes. Please do not send any notes not related to fitness to drive.

Applicants full name

Date of birth D D M M Y Y

7 Consultants details

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

Consultant in

Name

Address

Date of last appointment D D M M Y Y

Consultant in

Name

Address

Date of last appointment D D M M Y Y

Consultant in

Name

Address

Date of last appointment D D M M Y Y

8 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:	

9 Additional information

Patient's weight (kg)

Height (ems)

Details of smoking habits, if any

Number of alcohol units taken each week

10 Examining doctor's signature and stamp

To be completed by the doctor carrying out the examination.

Please ensure all sections of the form have been completed. The form will be returned to you if you don't do this.

I confirm that this report was completed by me at examination. I also confirm 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.

I have examined the above named peson for a taxi/private hire drivers licence and find him/her*

☐ **fit** ☐ **not fit** **(please tick as applicable)**

to hold that licence.

(*Delete as applicable) .

☐ Please confirm you have viewed the patients full medical report

Signature of practitioner

Date of signature D D M M Y Y

Doctor's stamp

Applicants full name

Date of birth D D M M Y Y

This page must be completed by the applicant
Applicant's consent and declaration

You **must** fill in this section and must **not** alter it in any way.

Consent and declaration

I authorise my doctor(s) and specialist(s) to release reports/medical information about my condition relevant to my fitness to drive, to the Secretary of State's medical adviser.

I authorise the Secretary of State to disclose such relevant medical information as may be necessary to the investigation of my fitness to drive, to doctors, paramedical staff and panel members.

I declare that I have checked the details I have given on the enclosed questionnaire 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 driving licence and can lead to prosecution.

Name	
Signature	
Date	

Check list

- Have you signed and dated the consent and declaration? ☐
- Have you checked that the report has been fully filled in by the optician/doctor and all relevant hospital notes have been enclosed? ☐