BOROUGH OF BARROW-IN-FURNESS
HACKNEY CARRIAGE/PRIVATE HIRE VEHICLE DRIVERS

MEDICAL EXAMINATION

Notes: You should complete Part A without signing the form at this stage. **You should arrange for a medical examination to be carried out by your own Medical Practitioner** who should complete Part B below. Any consequential fee for this service is payable direct by the applicant to the Medical Practitioner. **This completed form must be returned to the Council along with your application for your driver's licence**. Please note that a medical report must be submitted when the applicant reaches their 50th, 56th, 59th or 62nd birthday. Once you reach the age of 65 years a full medical is required annually, and should be submitted with your renewal application form.

PLEASE COMPLETE IN BLACK INK

Part A

Name of Applicant (Block Capitals)	
Address & Postcode	
Date of Birth	
Signature of Applicant (sign in the presence of the Medical Practitioner signing this certificate)	

Part B

Being a registered medical practitioner who is competent in undertaking DVLA Group 2 medical examinations, I have today examined the above applicant. I have examined the applicant medically to DVLA Group 2 medical standards for vocational drivers and have had access to the applicant's full medical records and I consider the above applicant (please tick one box):

[ ] Meets the DVLA Group 2 medical standards for vocational drivers to drive a hackney carriage or private hire vehicle

[ ] Does not meet the DVLA Group 2 medical standards for vocational drivers to drive a hackney carriage or private hire

Signature of Medical Practitioner: ……..

Name BLOCK CAP: ……..

Date: ……..

Surgery Address or Stamp

HACKNEY CARRIAGE/PRIVATE HIRE DRIVER

MEDICAL REPORT

Application for a Hackney Carriage/Private Hire Driving Licence.

- If this is the first application for one of the above licences, you must arrange for a medical examination to be carried out by a Medical Practitioner. You should take this form along with you in order that the Doctor can use it as an aide memoir when carrying out the examination. A further Medical Report is required when the applicant reaches their 50th, 56th, 59th or 62nd birthday. Applicants aged 65 or over must return the form duly completed with every application for the renewal of a driver's licence.

- Your Doctor will come to a decision as to your fitness to drive using Group 2 standards for vocational drivers as laid down by the DVLA.

A. WHAT YOU HAVE TO DO

1. **Before** consulting the Doctor please read the notes overleaf at Section C, paragraphs 1, 2 and 3. If you have any of these conditions you may not be granted a licence to drive Hackney Carriage/Private Hire Vehicles.

2. If, after reading the notes, you have any doubts about your ability to meet the medical or eyesight standards, consult your Doctor/Optician **before** you arrange for this medical form to be completed. The Doctor will normally charge you for completing it. In the event of your application being refused, the fee you pay the Doctor is **not** refundable. Barrow Borough Council has **no** responsibility for the fee payable to the Doctor.

3. Fill in Section 8 and Section 9 of this report in the presence of the Doctor carrying out the examination.

4. Barrow Borough Council must receive this report, signed by the Doctor, together with your application, within 3 months of the Doctor signing the medical report. Failure to submit both forms together will lead to difficulties and delay in processing your application.

5. Applicants who have completed a medical examination in connection with the driving other large or passenger carrying vehicles within the last three years may be excused re examination upon written evidence from their Doctor.

B. WHAT THE DOCTOR HAS TO DO

1. Please arrange for the patient to be seen and examined.

2. Please complete sections 1-7 and 10 of this report. You may find it helpful to consult DVLA's "At a Glance Guide for medical practitioners for the current medical standards of fitness to drive" and the Medical Commission on Accident Prevention booklet - "Medical Aspects of Fitness to Drive".

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 which could affect safe driving and they hold any type of driving licence, they must inform the Licensing Officer, Town Hall, Barrow-in-Furness, LA14 2LD immediately.

4. Please ensure that you have completed all the sections.

   If this report does not bring out important clinical details with respect to driving, please give details in section 7.

C. MEDICAL STANDARDS FOR DRIVERS OF MEDIUM/LARGE GOODS OR PASSENGER CARRYING VEHICLES

Medical standards for drivers of Hackney Carriages and Private Hire vehicles are higher than those required for car drivers.

The following conditions are a bar to the holding of either of these entitlements.

1. **Epileptic attack**

   Applicants must have been free of epileptic seizures for at least the last ten years and have not taken anti-epileptic medication during this ten year period. Barrow Borough Council may refuse or revoke the licence if these conditions cannot be met.

2. **Diabetes**

   Insulin treated diabetics may not obtain a licence.

3. **Eyesight**

   All applicants, for whatever category of vehicle, must be able to read in good daylight a number plate at 20.5 metres (67 feet), and, if glasses or corrective lenses are required to do so, these must be worn while driving. In addition:

(i) Applicants for Hackney Carriage and Private Hire vehicles must have:

- A visual acuity of at least 6/9 in the better eye; and
- A visual acuity of at least 6/12 in the worse eye; and
- If these are achieved by correction the uncorrected visual acuity in each eye must be no less than 3/60.

An applicant who held a licence before 1 June 2001 and who has an uncorrected acuity of less than 3/60 in only one eye may be able to meet the required standard and should check with Drivers Medical Group, D7, DVLA, Swansea, SA99 1TU, or telephone 0300 7906807, about the requirement.

(ii) Applicants are also banned by law from holding medium/large goods or passenger carrying vehicle entitlement if they have:

- uncontrolled diplopia (double vision)
- or do not have a normal binocular field of vision

An applicant (or existing licence holder) failing to meet the epilepsy, diabetes or eyesight regulations must be refused by law.

4. **Other Medical Conditions**

In addition to those medical conditions covered above, applicants (or licence holders) are likely to be refused if they are unable to meet the national recommended guidelines in the following cases:

- Within 3 months of myocardial infarction, any episode of unstable angina, CABG or coronary angioplasty
- A significant disturbance of cardiac rhythm occurring within the past 5 years unless special criteria are met
- Suffering from or receiving medication for angina or heart failure
- Hypertension where the BP is persistently 180 systolic or over or 100 diastolic or over
- A stroke, or TIA within the last 12 months
- Unexplained loss of consciousness within the past 5 years
- Meniere's and other conditions causing disabling vertigo, within the past 1 year, and with a liability to recurrence
- Recent severe head injury with serious continuing after effects, or major brain surgery
- Parkinson's disease, multiple sclerosis or other "chronic" neurological disorders likely to affect limb power and co-ordination
- Suffering from a psychotic illness in the past 3 years, or suffering from dementia
- Alcohol dependency or misuse, or persistent drug or substance misuse or dependency in the past 3 years
- Insuperable difficulty in communicating by telephone in an emergency
- Any other serious medical condition which may cause problems for road safety when driving a Medium/Large Goods or Passenger Carrying Vehicle.
- If major psychotropic or neuroleptic medication is being taken
- Any malignant condition within the last 2 years likely to metastasise to the brain eg Ca lung or malignant melanoma

Medical Examination to be filled in by the Doctor.
The Patient must fill in sections 9 and 10 in the Doctor's presence
Please answer ALL questions

Patients Name _____ **DOB** _____

Please give patient's weight ☐ kg/st and height ☐ ft/cms

Details of smoking habits, if any ☐

Number of alcohol units taken each week ☐

	Yes	**No**
Is the urine analysis positive for Glucose ?(please tick √ appropriate box)	☐	☐

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

1	2	3

Date of last appointment d d m m y y d d m m y y

Medication	Dosage	Reason Taken

SECTION 1. Vision (Please see Eyesight notes 3i to 3ii)

Please tick √ the appropriate box(es)	**Yes**	**No**
1. Is the visual acuity **at least** 6/9 in the better eye and at least 6/12 in the other? (corrective lenses may be worn) as measured with the full size 6m snellen chart.	☐	☐
2. Do corrective lenses have to be worn to achieve this standard?	☐	☐
If **YES** is the :-		
(a) Uncorrected acuity at least 3/60 in the right eye?	☐	☐
(b) Uncorrected acuity at least 3/60 in the left eye? (3/60 being the ability to read the 6/60 line of the full size 6m Snellen chart at 3 metres)	☐	☐
(c) Correction well tolerated?	☐	☐

3. Please state all the visual acuities **of each eye** in terms of the 6m Snellen chart. Please convert any 3 meter readings to the 6 metre equivalent.

Uncorrected				**Corrected** (if applicable)			
Right		Left		Right		Left	

		Yes	**No**
4.	Is there a defect in the patient's binocular field of vision (central and/or peripheral)?	☐	☐
5.	Is there diplopia (controlled or uncontrolled)?	☐	☐
6.	Does the patient have any ophthalmic condition?	☐	☐

If **YES** to 4,5 or 6 please give details in **Section 7** and enclose any relevant visual field charts or hospital letters

SECTION 2 - Nervous System

		Yes	No
1.	Has the patient had any form of epileptic attack? If **YES**, please answer questions a-f	☐	☐
(a)	Has the patient had more than one attack?	☐	☐

(b) Please give date of the first and last attack?

First attack d d m m y y Last attack d d m m y y

(c) Is the patient currently on anti-epilepsy medication?

If **YES** please fill in current medication on the appropriate section on the front of this form

(d) If treated, please give date when treatment ended d d m m y y

(e) Has the patient had a brain scan? If **YES** please state: Please supply reports if available

MRI d d m m y y CT d d m m y y

(f) Has the patient had an EEG?

If **YES** please provide d d m m y y dates

Please provide reports if possible

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

If Yes, please give date(s) and details in Section 7

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3. Is there a history of, or evidence of any of the conditions listed at a-g below ?

Yes ☐ **No** ☐

If **NO,** go to **Section 3**

If **YES** please tick the relevant box(es) and give dates and full details at **Section 7** and supply any relevant reports.

(a) Stroke/TIA *please delete as appropriate* ☐

If **YES**, please give date has d d m m y y there been a **full** recovery ☐ ☐

(b) Sudden disabling dizziness/vertigo within the last 1 year with a liability to recur? ☐

(c) Subarachnoid haemorrhage ☐

(d) Serious head injury within the last 10 years ☐

(e) Brain tumour, either benign or malignant, primary or secondary ☐

(f) Other brain surgery/abnormality ☐

(g) Chronic neurological disorders e.g. Parkinson's disease, Multiple Sclerosis ☐

SECTION 3 - Diabetes Mellitus

		Yes	No
1.	Does the applicant have diabetes mellitus?	☐	☐
	If **No,** proceed to **Section 4**		
	If **Yes**, please answer the following questions.		
2.	Is the diabetes managed by:		
	(a) Insulin?	☐	☐
	If **YES**, please give date started on insulin d d m m y y		
		Yes	**No**
(b)	Exenatide/Byetta	☐	☐
(c)	Oral hypoglycaemic agents and diet? If **YES** please fill in current medication on the appropriate section on the front of this form	☐	☐
(d)	Diet only?	☐	☐
3.	Does the patient test blood glucose at least twice every day?	☐	☐
4.	Is there evidence of:-	☐	☐
(a)	Loss of visual field?		
(b)	Severe peripheral neurophathy, sufficient to impair limb function for safe driving?	☐	☐
(c)	Diminished/Absent awareness of hypoglycaemia?	☐	☐
5.	Has there been laser treatment for retinopathy?	☐	☐
	If **YES** please give date(s) of treatment		
6.	Is there a history of hypoglycaemia during **waking** hours in the last 12 months requiring assistance from third party?	☐	☐
	If **YES** to any of 4-6 above, please give details in **Section 7**		

SECTION 4 - Psychiatric Illness

	Yes	No
Is there a history of, or evidence of any of the conditions listed at 1-7 below:-	☐	☐

If **NO** please go to **Section 5**

If **YES** please tick the relevant box(es) below and give date(s), prognosis, period of stability and details of medication, dosage and any side effects in **Section 7**

NB Please enclose relevant hospital notes

NB If patient remains under specialist clinic(s) ensure details are filled in at top of page 1

		Yes
1.	Significant psychiatric disorder within the past 6 months	☐
2.	A psychotic illness within the past 3 years, including psychotic depression	☐
3.	Dementia or cognitive impairment	☐
4.	Persistent alcohol misuse in the past 12 months	☐
5.	Alcohol dependency in the past 3 years	☐
6.	Persistent drug misuse in the past 12 months	☐
7.	Drug dependency in the past 3 years	☐

SECTION 5 - Cardiac

	Yes	No
Is there a history of, or evidence of Coronary Artery Disease?	☐	☐

If **NO** go to **Section 5B**

If **YES** please answer all questions below and give details at **Section 7** of the form and enclose relevant hospital notes.

SECTION 5A - Coronary Artery Disease

		Yes	No
1.	Acute Coronary Syndromes including Myocardial Infarction?	☐	☐
	If **YES**, please give date(s) d d m m y y		

		Yes	No
2.	Coronary artery by-pass graft surgery?	☐	☐
	If **YES**, please give date(s) d d m m y y		

		Yes	No
3.	Coronary Angioplasty (P.C.I)	☐	☐
	If **YES**, please give date of most recent intervention d d m m y y		

		Yes	No
4.	Has the patient suffered from Angina	☐	☐
	If **YES**, please give date of the last known attack d d m m y y		

Please go to Section 5B

SECTION 5B - Cardiac Arrhythmia

	Yes	No
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 7** of the form.

1.	Has there been a **significant** disturbance of cardiac rhythm? i.e. sinoatrial disease, significant antiro-ventricular conduction defect, atrial flutter/fibrillation, narrow or broad complex tachycardia in last 5 years	☐	☐

2. Has the arrhythmia been controlled satisfactorily for at least 3 months? ☐ ☐

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

4. Has a pacemaker been implanted? ☐ ☐
If **YES:-**
(a) Please supply date | d | d | m | m | y | y |

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

(b) Does the patient attend a pacemaker clinic regularly? ☐ ☐

Please go to Section 5C

SECTION 5C - Peripheral Arterial Disease (excluding Buerger's Disease) Aortic Aneurysm/Dissection

	Yes	**No**
Is there a history or evidence of ANY of the following:-	☐	☐

If **YES** please **tick** √ ALL relevant boxes below, and give details in **Section 7** of the form

If **NO** go to **Section 5D**

1. **PERIPHERAL ARTERIAL DISEASE (excluding Buerger's Disease)** ☐ ☐

2. Does the patient have claudication? ☐ ☐

If **YES** for how long in minutes can the patient walk at a brisk pace before being symptom limited?

Please give details ☐

3. **AORTIC ANEURYSM** ☐ ☐
IF YES:

(a) Site of Aneurysm: **Thoracic** ☐ **Abdominal** ☐

(b) Has it been repaired successfully? ☐ ☐

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

If **NO** please provide latest measurement and date obtained

☐ | | | | | | |

4. **DISSECTION OF THE AOTA REPAIRED SUCCESSFULLY:**

If yes please provide copies of all reports to include those dealing with any surgical treatment.

	Yes	No
Please go to Section 5D	☐	☐

SECTION 5D - Valvular/Congenital Heart Disease

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

If **NO** go to **SECTION 5E**

If **YES** please answer all questions below and give details in **SECTION 7** of the form.

		Yes	No
1.	Is there any history of congenital heart disorder?	☐	☐
2.	Is there a history of heart valve disease?	☐	☐
3.	Is there any history of embolism (**not** pulmonary embolism)	☐	☐
4.	Does the patient currently have significant symptoms?	☐	☐
5.	Has there been any progression since the last licence application? (if relevant)	☐	☐

Please go to Section 5E

SECTION 5E - Cardiac Other

	Yes	No
Does the patient have a history of **ANY** of the following conditions:-	☐	☐
(a) a history of, or evidence of heart failure?	☐	☐
(b) established cardiomyopathy?	☐	☐
(c) A heart of heart/lung transplant	☐	☐

If YES please give full details in Section 7 of the form. If NO go to Section 5F

SECTION 5 F - Cardiac Investigations (This Section must be filled in for all patients)

		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	☐	☐

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

If **YES** please give ☐☐☐☐☐☐ date and give details in **Section 7**

Please provide relevant reports if available

3.	Has an echocardiogram been undertaken (or planned)?	☐	☐

(a)
If **YES** please give date ☐☐☐☐☐☐ and give details in **Section 7**

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

please provide relevant reports if available

4.	Has a coronary angiogram been undertaken (or planned)?	☐	☐

If **YES** please give ☐☐☐☐☐☐ date and give details in **Section 7**

please provide relevant reports if available

5.	Has a 24 hour ECG tape been undertaken (or planned)?	☐	☐

If **YES** please give ☐☐☐☐☐☐ date and give details in **Section 7**

please provide relevant reports if available

6.	Has a Myocardian Perfusion Scan or Stress Echo study been undertaken (or planned?)	☐	☐

If **YES** please give ☐☐☐☐☐☐ date and give details in **Section 7**

please provide relevant reports if available

Please go to Section 5G

SECTION 5G - Blood Pressure (This Section must be filled in for all patients)

		Yes	No
1.	Is today's best systolic pressure reading 180mm Hg or more	☐	☐
2.	Is today's best diastolic pressure reading 100mm Hg or more	☐	☐
3.	Is the patient on anti-hypertensive treatment?	☐	☐

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

SECTION 6 - General

Please answer all questions in this section. If your answer is YES to any of the questions, please give. Full details **in Section 7**

		Yes	No
1.	Is there **currently** a disability of the spine or limbs, likely to impair control of the vehicle	☐	☐
2.	Is there a history of bronchogenic carcinoma or other malignant tumour, for example, malignant melanoma, with a significant liability to metastasis cerebrally?	☐	☐
(a)	Is there any evidence that patient has cancer that causes fatigue or cachexia that affects safe driving?	☐	☐

If **YES** please give dates and diagnosis and state whether there is current evidence of dissemination

		Yes	No
3.	Is the patient profoundly deaf? If yes	☐	☐
	Is the patient able to communicate in the event of an emergency by speech or by using a device, e.g. textaphone ?	☐	☐
4.	Is there a history of either renal or hepatic failure ?	☐	☐
5.	Is there a history of, or evidence of sleep apnoea syndrome? If **YES**, please provide details	☐	☐

(a) Date of diagnoses ☐☐☐☐☐☐

(b) Is it controlled successfully? ☐ ☐

(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

		Yes	No
6.	Does the patient suffer from narcolepsy/cataplexy?	☐	☐

If yes, please give details in Section 7

7.	Is there any other **Medical Condition,** causing excessive daytime sleepiness?	☐	☐

If **YES** please provide details

(a) Diagnosis

(b) Date of Diagnosis

(c)	Is it controlled successfully?	☐	☐

(d) If **YES**, please state treatment

(e) Please state period of control

(e) Date last seen by consultant

8.	Does the patient have severe symptomatic respiratory disease causing chronic hypoxia	☐	☐

9.	Does any medication currently taken cause the patient side effects that could affect safe driving ? If **YES** please provide details of medication	☐	☐

10	Does the patient have any medical condition that could affect safe driving ? If **YES** please provide details	☐	☐

SECTION 7

Please forward copies of relevant hospital notes **only.**
PLEASE DO NOT send any notes not related to fitness to drive

SECTION 8

MEDICAL PRACTITIONER DETAILS

TO BE FILLED IN BY THE DOCTOR CARRYING OUT THE EXAMINATION

Doctor's details

Name _____

Address _____

_____

_____

Email _____

Fax number _____

Surgery Stamp or GMC Registration Number

Signature of Medical Practitioner

Date of Examination

PATIENT'S DETAILS

To be filled in in the presence of the
Medical Practitioner carrying out the examination

Please make sure that you have printed your name and date of birth on each page before sending this form with your application

SECTION 9 - Your Details

Your Full Name _____

_____

Your Address_____

_____

_____

Email _____

Date of Birth_____

Home Phone Number_____

Mobile Number _____

About your GP/Group Practice

GP/Group Name _____

Address_____

_____

_____

Phone _____

Email _____

Fax number _____

SECTION 10 - Patient's Consent and Declaration

Consent and Declaration

This section **must** be completed and must **not** be altered in any way.

Please read the following important information carefully then sign the statements below.

Important information about Consent

On occasion, as part of the investigation into your fitness to drive, DVLA may require you to undergo a medical examination or some form of practical assessment. In these circumstances, those personnel involved will require your background medical details to undertake an appropriate and adequate assessment. Such personnel might include doctors, orthoptists at eye clinics or paramedical staff at a driving assessment centre. Only information relevant to the assessment of your fitness to drive will be released. In addition, where the circumstances of your case appear exceptional, the relevant medical information would need to be considered by one or more members of the Secretary of State's Honorary Medical Advisory Panels. The membership of these Panels conforms strictly to the principle of confidentiality.

Consent and Declaration

I authorise my Doctor(s) and Specialist to release report/medical information about my condition, relevant to my fitness to drive, to the Secretary of State's medical advisor.

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 and to inform my doctor(s) of the outcome of the case where appropriate.

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 it is a criminal offence if I make a false declaration to obtain a driving licence and can lead to prosecution".

Signature _____ **Date**_____