Hackney Carriage & Private Hire Drivers Medical Examination Report

SDC/1331/SEP14

Licensing, Environmental Services
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To be completed by the Doctor, and by the Patient at sections 9 and 10 in the Doctor's presence. Please use black ink and answer all questions.

Applicant's full name DOB DD MM YY

Please give patient's weight (kg/st) height (cms/ ft)

Please give details of smoking habits, if any

Please give number of alcohol units taken each week

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

Details of specialist(s)/ consultants, including address	1	2	3
Specialty			
Date last seen			

Medication	Dosage	Reason Taken

1 VISION (please see Eyesight notes on page 8 and 9 of leaflet INF4D)

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 the visual acuities **of each eye** in terms of the 6m Snellen chart.

   Please convert any 3 metre readings to the 6 metre equivalent.

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

	YES	NO
4 Is there a defect in his/her binocular field of vision (central and/or peripheral)?	○	○
5. Is there diplopia? (controlled or uncontrolled)?	○	○
6. Does the applicant have any other 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.

2 NERVOUS SYSTEM

	YES	NO
1. Has the applicant had any form of epileptic attack?	○	○
(a) If YES, please give details of last attack	DD MM YY	
(b) If treated, please give date when treatmentceased	DD MM YY	
(c) Is the applicant currently on anti-epileptic medication?	○	○

If **YES**, please complete current medication on the appropriate section on the front of this form

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**	○	○
3. Does the applicant suffer from narcolepsy/cataplexy? If **YES**, please give details in **Section 7**	○	○
4. Is there a history of, or evidence of any of the conditions listed at a–h below? If **NO**, go to **Section 3.** If **YES**, please tick the relevant box(es) and give dates and full details at **Section 7**.	○	○
(a) Stroke/ TIA *(please delete as appropriate)*	○	○
If **YES**, please give date DD MM YY has there been a full recovery?	○	○
(b) Sudden and 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	○	○
(g) Chronic neurological disorders e.g. Parkinson's disease, Multiple Sclerosis	○	○
(h) Dementia or cognitive impairment	○	○

3 DIABETES MELLITUS

	YES	NO
1. Does the applicant have diabetes mellitus? If **NO**, please 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 DD MM YY		
(b) Exenatide/Byeta	○	○
(c) Oral hypoglycaemic agents and diet? If **YES**, please complete current medication on the appropriate section on the front of this form	○	○
(d) Diet only?	○	○
3. Does the applicant test blood glucose at least twice every day?	○	○
4. Is there evidence of:-		
(a) Loss of visual field?	○	○
(b) Severe peripheral neuropathy, 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 DD MM YY DD MM YY DD MM YY		
6. Is there a history of hypoglycaemia during waking hours in the last 12 months requiring assistance from a third party?	○	○

If **YES** to any of 4–6 above, please give details in **Section 7**

4 PSYCHIATRIC ILLNESS

	YES	NO
Is there a history of, or evidence of any of the conditions listed at 1–6 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 applicant remains under specialist clinic(s) ensure details are completed at the 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. Persistent alcohol misuse in the past 12 months	○
4. Alcohol dependency in the past 3 years	○
5. Persistent drug misuse in the past 12 months	○
6. Drug dependency in the past 3 years	○

5 CARDIAC

Please follow the instructions in all Sections (5A–5G) giving details as required in **Section 7** and enclose hospital notes relevant to this condition.

NB. If applicant remains under specialist cardiac clinic(s) ensure details are completed on page 1.

5A Coronary Artery Disease

	YES	NO
Is there a history of, or evidence of, coronary artery disease?	○	○

If **NO**, proceed to **Section 5B**
If **YES** please answer all questions below and give details at **Section 7** of the form.

1. Acute Coronary Syndrome including Myocardial Infarction?	○	○
If **YES**, please give date(s) DD MM YY		
2. Coronary artery by-pass graft surgery?	○	○
If **YES**, please give date(s) DD MM YY		
3. Coronary Angioplasty (P.C.I)	○	○
If **YES**, please give date(s) DD MM YY		
4. Has the applicant suffered from Angina?	○	○
If **YES**, please give the date of the last attack DD MM YY		

Please proceed to next Section 5B

5B Cardiac Arrhythmia

	YES	NO
Is there a history of, or evidence of, cardiac arrhythmia?	○	○

If **NO**, proceed to **Section 5C**
If **YES** please answer all questions below and give details at **Section 7** of the form.

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 last 5 years	○	○
2. Has the arrhythmia been controlled satisfactorily for at least 3 months?	○	○
3. Has a cardiac defibrillator device (I.C.D) been implanted?	○	○
4. Has a pacemaker been implanted?	○	○
If **YES**:-		
(a) Please supply date DD MM YY		
(b) Is the applicant free of symptoms that caused the device to be fitted?	○	○
(c) Does the applicant attend a pacemaker clinic regularly?	○	○

Please proceed to next Section 5C

5C Peripheral Arterial Disease (excluding Buerger's Disease)

	YES	NO
1. Is there a history or evidence of ANY of the below: If **YES** please tick ✓ ALL relevant boxes below, and give details at **Section 7** of the form.	○	○

PERIPHERAL ARTERIAL DISEASE (excluding Buerger's Disease)

2. Does the patient have claudication?	○	○

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

Please give details

AORTIC ANEURYSM	○	○

If **YES**:

(a) Site of Aneurysm: Thoracic ○ Abdominal ○

(b) Has it been repaired successfully?	○	○
(c) Is the transverse diameter currently 5.5cms?	○	○

DISSECTION OF THE AORTA

IF REPAIRED SUCCESSFULLY:

(d) Please provide sight of reports to confirm if available

Please proceed to next Section 5D

5D Valvular/Congenital Heart Disease

	YES	NO
Is there a history of, or evidence, of valvular/congenital heart disease?	○	○

If **NO**, proceed to **Section 5E**
If **YES** please answer all questions below and give details at **Section 7** of the form.

1. Is there a 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 applicant currently have significant symptoms?	○	○
5. Has there been any progression since the last licence application? (if relevant)	○	○

Please proceed to next Section 5E

5E Cardiac Other

	YES	NO
Does the applicant have a history of ANY of the following conditions:		
(a) a history of, or evidence of heart failure?	○	○
(b) established cardiomyopathy?	○	○
(c) a heart or heart/lung transplant?	○	○

If YES to any part of the above, please give full details in Section 7 of the form. If NO, proceed to next section 5F.

5F Cardiac Investigations

This section must be completed for ALL applicants.

	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?	○	○
2. Has an exercise ECG been undertaken (or planned)? *(Please provide copy if available)*	○	○
If **YES**, please give date DD MM YY and give details in **Section 7**		
3. Has an echocardiogram been undertaken (or planned)? *(Please provide copy if available)*	○	○
(a) If **YES**, please give date DD MM YY and give details in **Section 7**		
(b) If undertaken, is/was the left ventricular ejection fraction greater than or equal to 40%?	○	○
4. Has a coronary angiogram been undertaken (or planned)? *(Please provide copy if available)*	○	○
If **YES**, please give date DD MM YY and give details in **Section 7**		
5. Has a 24 hour ECG tape been undertaken (or planned)? *(Please provide copy if available)*	○	○
If **YES**, please give date DD MM YY and give details in **Section 7**		
6. Has a myocardial perfusion scan or stress echo study been undertaken (or planned)?	○	○
If **YES**, please give date DD MM YY and give details in **Section 7** *(Please provide copy if available)*		

Please proceed to Section 5G

5G Blood Pressure

This section must be completed for ALL applicants.

	YES	NO
1. Is today's best reading systolic pressure 180mm Hg or greater?	○	○
2. Is today's best reading diastolic pressure 100mm Hg or greater?	○	○
3. Is the applicant on anti-hypertensive treatment?	○	○

If **YES**, to any of the above, please supply today's best reading and three previous readings with dates, if available

		DD	MM	YY		DD	MM	YY		DD	MM	YY

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 metastasise cerebrally? If **YES**, please give dates and diagnosis and state whether there is current evidence of dissemination	○	○

DD MM YY

DD MM YY

DD MM YY

3. Is the applicant profoundly deaf?	○	○
If **YES**, is he/she able to communicate in the event of an emergency by speech or by using a device, e.g. a MINICOM/ text phone?	○	○
4. Is there a history of either renal or hepatic failure?	○	○
5. Does the applicant have sleep apnoea syndrome?	○	○

If **YES**, please supply details

(a) Date of diagnosis DD MM YY

(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 DD MM YY

6. Is there any other Medical Condition, causing excessive daytime sleepiness?	○	○

If **YES**, please supply details

(a) Diagnosis

(b) Date of diagnosis DD MM YY

(c) Is it controlled successfully? ○ ○

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

(e) Please state period of control

(f) Date last seen by consultant DD MM YY

7. Does the applicant have severe symptomatic respiratory disease causing chronic hypoxia?	○	○
8. Does any medication currently taken cause the applicant side effects that could affect safe driving?	○	○

If **YES**, please supply details of medication

9. Does the applicant have any other medical condition that could affect safe driving?	○	○

If **YES**, please supply details

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

8 MEDICAL PRACTITIONER DETAILS

To be completed by Doctor carrying out the examination

Doctor's Name

Address

E-mail address

Fax number

Surgery Stamp

I declare this applicant to be FIT TO DRIVE a licensed vehicle

Signature of Medical Practitioner

Date DD MM YY

I declare this applicant to be UNFIT TO DRIVE a licensed vehicle

Signature of Medical Practitioner

Date DD MM YY

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APPLICANT'S DETAILS

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

9 YOUR DETAILS

Your full name

Date of Birth DD MM YY

Your address

Work/Daytime telephone number

Home telephone number

E-mail address

About your GP/Group Practice

GP/Group name

Address

Telephone

E-mail address

Fax number

10 APPLICANT'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, Stratford-on-Avon District Council 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.

- I authorise my Doctor(s) and Specialist(s) to release report/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, 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 that it is a criminal offence if I make a false declaration to obtain a driving licence and can lead to prosecution."

Signature | Date DD MM YY

Stratford-on-Avon District Council is under a duty to protect the public funds it administers, and to this end may use the information you have provided on this form for the prevention and detection of fraud. It may also share this information with other bodies responsible for auditing or administering public funds for these purposes.

For further information, see http://www.stratford.gov.uk/datamatching