TORBAY COUNCIL

Licensing Team, Town Hall, Castle Circus, Torquay TQ1 3DR
www.torbay.gov.uk

MEDICAL ASSESSMENT

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

Notes for the Applicant

This medical assessment must be carried out by a General Practitioner in the medical practice to which you are registered or any other GP at another practice provided they have access to your full medical records or any GMC (General Medical Council) registered doctor who is licensed to practice in the UK providing the doctor has access to your full medical records.

The vision assessment 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.

IMPORTANT: ASSESSMENTS ARE ONLY VALID FOR 3 MONTHS FROM THE DATE THE DOCTOR AND/OR OPTICIAN OR OPTOMOTRIST SIGNS IT.

Applicant's Details:

Full name: Date of Birth: Age: …….

Address:

Post Code:

Contact telephone number: Email:

Notes for Applicant

A medical examination will be required if you:

Are a new applicant

Are an existing driver and reached 45 years of age (MEDICAL REQUIRED EVERY 5 YEARS THEREAFTER UNTIL YOU REACH 65 YEARS OF AGE)

Have reached 65 years of age (MEDICAL REQUIRED EVERY 1 YEAR THEREAFTER) or:

Has suffered a DVLA Notifiable illness since your last licence.

ALL FEES ARE THE RESPONSIBILITY OF THE APPLICANT

Applicant's consent and declaration

I authorise my General Practitioner(s) to provide the information requested on this form relevant to my fitness to drive a licensed hackney carriage or private hire vehicle to Torbay Council in order to assess my fitness to hold a dual licensed drivers badge.

I declare that to the best of my knowledge and belief all information given by me to my Doctor in connection with this examination is true.

Signed:	Date:

General Practitioner

This form must be completed in full by the General Practitioner or Doctor who has reviewed the applicant's full medical records. Please answer all questions and once completed sign the declaration at the end.

Torbay Council's policy on medical fitness requires that dual licensed drivers meet Group 2 Medical Standards, as set out in the DVLA publication '*Assessing fitness to drive - a guide for medical professionals*'.
www.gov.uk/government/publications/assessing-fitness-to-drive-a-guide-for-medical-professionals

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 hackney carriage and private hire 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 full medical records? If reviewing a printout of the full medical records you must provide the date of printout: Date –	YES	NO

Section 1

Vision Assessment – to be completed by the GP or Optician/Optometrist

Please see 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

		YES	NO
1	Please confirm the scale you are using to express the driver's visual acuities: ☐ Snellen ☐ Snellen expressed as a decimal ☐ LogMAR		
2	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)	☐	☐
3	Were corrective lenses worn to meet this standard? If **Yes** please indicate if: ☐ Glasses ☐ Contact lenses ☐ Both	☐	☐

4	Uncorrected		Corrected (using the prescription worn for driving)	
	Right	Left	Right	Left

5	If **glasses** (not contact lenses) are worn for driving, is the corrective power greater than +8 dioptres in any meridian of either lens?	☐	☐
6	If a correction is worn for driving, is it well tolerated?	☐	☐
7	Is there a history of any medical condition that may affect the applicant's binocular field of vision (central and / or peripheral)?	☐	☐
8	Is there diplopia (controlled or uncontrolled)?	☐	☐
9	Does the applicant, on questioning, report symptoms of intolerance to glare and / or impaired contrast sensitivity and / or impaired twilight vision?	☐	☐
10	Does the applicant have any other ophthalmic condition?	☐	☐

If **YES** to questions 7, 8, 9 or 10 please give details in **Section 7**.

In relation to Section 1 does the applicant meet the DVLA Group 2 medical standards	**YES** ☐	**NO** ☐

If **NO** please indicate reasons why:

If eye examination has been completed by an Optician/Optometrist please give details below:

Name:

Address:

Contact telephone number:

Optician / Optometrist Stamp:
FORM WILL NOT BE ACCEPTED WITHOUT AN OFFICIAL STAMP

Section 2

NERVOUS SYSTEM

			YES	NO
1	Has the applicant had any form of seizure? If **YES** please answer questions a – f below.		☐	☐
	a	Has the applicant had more than one attack?	☐	☐
	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 7.**		
	d	If no longer treated, please give date when treatment ended.		
	e	Has the applicant had a brain scan? If **YES** please state dates below.	☐	☐
		MRI: **CT:**		
	f	Has the applicant had an EEG? If **YES** please provide date and details in **Section 7**	☐	☐
2	Is there a history of blackout or impaired consciousness within the last 5 years? If **YES** please give dates and details at **Section 7**:		☐	☐
3	Does the applicant suffer from narcolepsy? If **YES** please give dates and details in **Section 7.**		☐	☐
4	Is there a history of, or evidence of, any of the conditions listed at a – h below? If **NO** please complete the declaration at the bottom of the page and then go to Section 3 If **YES** please answer the following questions and give dates in **section 7**.		☐	☐
	a	Stroke / TIA (please delete as appropriate) If YES please give date:	☐	☐
		Has there been a full recovery?	☐	☐
	b	Sudden and disabling dizziness/vertigo within the last one year with a liability to recur	☐	☐
	c	Subarachnoid haemorrhage	☐	☐
	d	Serious traumatic brain injury within the last 10 years	☐	☐
	e	Any form of brain tumour	☐	☐
	f	Other brain surgery or abnormality	☐	☐
	g	Chronic neurological disorders	☐	☐
	h	Parkinson's disease	☐	☐

In relation to Section 2 does the applicant meet the DVLA Group 2 medical standards?	**YES** ☐	**NO** ☐

If not please indicate reasons why

Section 3

DIABETES MELLITUS

			YES	NO
1	Does the applicant have diabetes mellitus? If **NO** please complete the declaration at the bottom of the page and then go 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:	☐	☐
	b	If treated with insulin, are there at least 3 months of blood glucose readings stored in a memory meter? If **NO**, please give details in **Section 7**	☐	☐
	c	Other injectable treatments?	☐	☐
	d	A Sulphonylurea or a Glinide?	☐	☐
	e	Oral hypoglycaemic agents and diet? If **YES** please provide details of medication:	☐	☐
	f	Diet only?	☐	☐
	If **YES** to any of (a) – (e) above, please give details in **Section 7**			
3	a	Does the applicant test blood glucose at least twice every day?	☐	☐
	b	Does the applicant test at times relevant to 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?	☐	☐
4	Is there any evidence of impaired awareness of hypoglycaemia?		☐	☐
5	Is there a history of hypoglycaemia in the last 12 months requiring the assistance of another person?		☐	☐
6	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 or 4 – 6 above, please give details in **Section 7**				
7	Has there been any laser treatment or intra-vitreal for retinopathy? If **YES** please give date(s) of treatment:		☐	☐

In relation to Section 3 does the applicant meet the DVLA Group 2 medical standards?	**YES** ☐	**NO** ☐

If not please indicate reasons why

Section 4

CARDIAC

4A CORONARY ARTERY DISEASE

	Is there a history of, or evidence of, Coronary Artery Disease? If **NO** please go to Section 4B. If **YES** please answer all questions below and give details at **Section 7** of the form.	**YES**	**NO**
1	Acute coronary syndrome including myocardial infarction? If **YES** please give date(s):	☐	☐
2	Coronary artery by-pass graft surgery? If **YES** please give date(s):	☐	☐
3	Coronary Angioplasty (P.C.I.)? If **YES** please give date of most recent intervention:	☐	☐
4	Has the applicant suffered from angina? If **YES** please give the date of the last known attack:	☐	☐

4B CARDIA ARRHYTHMIA

	Is there a history of, or evidence of, cardiac arrhythmia? If **NO**, go to Section 4C If **YES** please answer all questions below and give details in **Section 7**.	**YES**	**NO**
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 an ICD or biventricular pacemaker (CRST-D type) been implanted?	☐	☐
4	Has a pacemaker been implanted? If **YES**:	☐	☐
	a Please supply date:		
	b Is the applicant free of symptoms that caused the device to be fitted?	☐	☐
	c Does the applicant attend a pacemaker clinic regularly?	☐	☐

4C	PERIPHERAL ARTERIAL DISEASE (EXCLUDING BUERGER'S DISEASE) AORTIC ANEURYSM/DISSECTION				
Is there a history or evidence of **ANY** of the conditions listed at 1 – 5 below? If **NO** go to Section **4D.** If **YES** please answer the questions below and give details in **Section 7**				**YES**	**NO**
1	Peripheral Arterial Disease (excluding Buerger's Disease)			☐	☐
2	Does the applicant have claudication? If **YES,** how long in minutes can the applicant walk at a brisk pace before being symptom limited?:			☐	☐
3	Aortic Aneurysm If **YES:**			☐	☐
	a	Site of Aneurysm (please tick):	Thoracic ☐	Abdominal ☐	
	b	Has it been repaired successfully?		☐	☐
	c	Is the transverse diameter **currently** >5.5cm?		☐	☐
		If **NO** please provide latest measurement:		Date obtained:	
4	Dissection of the Aorta repaired successfully. If **YES,** please provide details in **Section 7**			☐	☐
5	Is there history of Marfan's disease? If **YES**, please provide details in **Section 7**			☐	☐

4D	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 7**			
1	Is there a history of congenital heart disorder?	☐	☐
2	Is there a history of heart valve disease?	☐	☐
3	Is there a history of aortic stenosis?	☐	☐
4	Is there any history of embolism? (not pulmonary embolism)	☐	☐
5	Does the applicant currently have significant symptoms?	☐	☐
6	Has there been any progression since the last licence application? (if relevant)	☐	☐

4E	CARDIAC OTHER		
Does the applicant have a history of **ANY** of the following conditions? If **NO** go to Section 4F. If **YES** please answer **ALL** questions below and give details in **Section 7**		**YES**	**NO**
a	A history of, or evidence of, heart failure?	☐	☐
b	Established cardiomyopathy?	☐	☐
c	Has a left ventricular assist device (LVAD) been implanted?	☐	☐
d	A heart or heart/lung transplant?	☐	☐
e	Untreated atrial myxoma?	☐	☐

4F	CARDIAC INVESTIGATIONS (This section must be filled in for all applicants)			
1	Has a resting ECG been undertaken? If **YES** does it show:		**YES** ☐	**NO** ☐
	a	Pathological Q waves?	☐	☐
	b	Left bundle branch block?	☐	☐
	c	Right bundle branch block?	☐	☐
2	Has the exercise ECG been undertaken (or planned)?		☐	☐
	If **YES** please provide date and give details in **Section 7**			
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%?	☐	☐
4	Has a coronary angiogram been undertaken (or planned)?		☐	☐
	If **YES** please provide date and give details in **Section 7:**			
5	Has a 24 hour ECG tape been undertaken (or planned)?		☐	☐
	If **YES** please provide date and give details in **Section 7**			
6	Has a Myocardial Perfusion Scan or Stress Echo study been undertaken (or planned)?		☐	☐
	If **YES** please provide date and give details in **Section 7**			

4G	BLOOD PRESSURE (This section must be filled in for all applicants)			
	Please record today's blood pressure reading:			
	Is the applicant on anti-hypertensive treatment?		Yes ☐	No ☐
	If **YES** please provide three previous readings with dates if available:			
	1	B.P. reading:	Date:	
	2	B.P. reading:	Date:	
	3	B.P. reading:	Date:	

In relation to Section 4 does the applicant meet the DVLA Group 2 medical standards?	**YES** ☐	**NO** ☐

If not please indicate reasons why

Section 5

PSYCHIATRIC ILLNESS

Is there a history of, or evidence of **ANY** of the conditions listed at 1 – 9 below? If **NO** please complete the declaration at the end of the section and go to Section 6.		**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 7**. (Please enclose relevant notes). (If applicant remains under specialist clinic(s) please give details in **Section 7**).			
1	Significant psychiatric disorder within the past 6 months?	☐	☐
2	Psychosis or hypomania/mania within the past 3 years, including psychotic depression?	☐	☐
3	Dementia or cognitive impairment?	☐	☐
4	Persistent alcohol misuse in the past 12 months?	☐	☐
5	Alcohol dependence in the past 3 years?	☐	☐
6	Does the applicant show any evidence of being addicted to the excessive use of alcohol?	☐	☐
7	Persistent drug misuse in the past 12 months?	☐	☐
8	Does the applicant show any evidence of being addicted to the excessive use of drugs?	☐	☐
9	Drug dependency in the past 3 years?	☐	☐
In relation to Section 5 does the applicant meet the DVLA Group 2 medical standards?		**YES** ☐	**NO** ☐

If not please indicate reasons why

Section 6

GENERAL

Please answer all questions in this section. If your answer is **YES** to any question please give full details in **Section 7.** Please complete the declaration at the end of the section.

			YES	NO
1	Is there **currently** any functional impairment that is likely to affect control of the vehicle?		☐	☐
2	Is there a history of bronchogenic carcinoma or other malignant tumour with a significant liability to metastasise cerebrally?		☐	☐
3	Is there any illness that may cause fatigue or cachexia that affects safe driving?		☐	☐
4	Is the applicant profoundly deaf?		☐	☐
	If **YES** is the applicant able to communicate in the event of an emergency by speech or by using a device? (e.g. a textphone)		☐	☐
5	Does the applicant have a history of liver disease of any origin?		☐	☐
6	Is there any history of renal failure?		☐	☐
7	Is there a history of, or evidence of, obstructive sleep apnoea syndrome or any other medical condition causing excessive day time sleepiness?		☐	☐
	If **YES** please provide details:			
	a	Date of diagnosis:		
	b	Is it controlled successfully?	☐	☐
	c	If YES please state treatment:		
	d	Please state period of control:		
	g	Date last seen by consultant:		
8	Does the applicant have severe symptomatic respiratory disease causing chronic hypoxia?		☐	☐
9	Does any medication currently taken cause the applicant side effects that could affect safe driving?		☐	☐
	If **YES** please provide details in **Section 7.**:			
10	Does the applicant have an ophthalmic condition?		☐	☐
11	Does the applicant have any other medical condition that could affect safe driving?		☐	☐
	If **YES** please provide details in **Section 7**.			
12	The applicant/driver is an insulin dependent diabetic?		☐	☐
13	If insulin dependent diabetic, does applicant satisfy the DVLA Group 2 requirements?	☐N/A	☐	☐
14	The applicant is medically able to carry assistance dogs in their vehicle?		☐	☐
In relation to Section 6 does the applicant meet the DVLA Group 2 medical standards?			**YES** ☐	**NO** ☐

If not please indicate reasons why

Section 7

Additional Information

PLEASE ENSURE YOU COMPLETE AND SIGN THE LAST PAGE OF THIS MEDICAL ASSESSMENT

General Practitioner / Doctor Declaration:

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

If you haven't reviewed his/her full medical records then **DO NOT** complete the declaration.

I certify that;

- I am familiar with the current requirements of the **DVLA Group 2 Medical Standards** applied by the DVLA in the current version of '*Assessing fitness to drive - a guide for medical professionals*'.
- I have reviewed the applicant's full medical records and that in my opinion nothing therein contradicts or tends to contradict the information given to me by the applicant.
- 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 vehicle under the **DVLA Group 2 Medical Standards**

Having regard to the above I certify that the applicant;

☐ **MEETS** ***(i.e. fit to act as a driver of a licensed vehicle)***

☐ **DOES NOT MEET** ***(i.e. unfit to act as a driver of a licensed vehicle)***

the minimum standards required for the DVLA Group 2 Medical Standards

Applicant Full Name: PLEASE PRINT IN BLOCK CAPITALS	Surgery / Medical Centre Stamp: FORM WILL NOT BE ACCEPTED WITHOUT AN OFFICIAL STAMP
Surgery / Medical Centre Name:	
Surgery / Medical Centre Address:	
GP / Doctor's Name: PLEASE PRINT IN BLOCK CAPITALS	
GP / Doctor's G.M.C. Registration No. PLEASE PRINT IN BLOCK CAPITALS	
GP's Signature:	Date:

Date of Issue:

Reference:

e-mail: licensing@torbay.gov.uk