Basingstoke and Deane
Hart DISTRICT COUNCIL
working together

Please note applicants must pay a £35.00 fee upon submission of this form.

This can be done at Deane's Reception or via the online payment facilities available.

All sections of this form must be completed.

Applicant's name | DOB:

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Hart DISTRICT COUNCIL

LICENSING

REPORT OF MEDICAL EXAMINATION OF APPLICANT FOR HACKNEY CARRIAGE OR PRIVATE HIRE DRIVER'S LICENCE

Local Government (Miscellaneous Provisions) Act 1976

FRONT PAGE TO BE COMPLETED BY APPLICANT

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

Name of Applicant:
Biological Sex of Applicant: Male Female (please circle)

Address of Applicant:

Postcode:

Contact Phone No.: **E-mail Address:**

Date of Birth:

Is this a new or renewal application? **New** ☐ **Renewal** ☐

Badge No: **Date First Issued:**

Name and address of doctor applicant is registered with:

APPLICANT'S DECLARATION AND CONSENT

Please read the following carefully and sign the statements below:

"I have read the notes overleaf and give my consent for the Council's Medical Advisor to consult my doctor(s) and specialist(s) regarding my medical examination for a Hackney Carriage or Private Hire driver's licence. I also give consent for my doctor(s) and specialist(s) to release information to the Council's Medical Adviser.

I understand the information in this report will be retained by the Licensing Department on a confidential basis."

Signed: **Date:**

Please forward this completed report to:

Shared Licencing Service, Basingstoke and Deane Borough Council, Civic Offices, London Road, Basingstoke, Hampshire, RG21 4AH
If you have any queries please contact the Licensing Team at the above address or telephone: 01256 844844 or 01252 622122 E-mail: licensing@basingstoke.gov.uk or Hartlicensing@basingstoke.gov.uk

Any fee charged by the GP is payable by the applicant to the Medical Practitioner.

Applicant's name DOB:

Information and Useful Notes for Applicants and Doctors

Hart District requires all applicants for Hackney Carriage or Private Hire drivers' licences to undergo a medical examination in line with the DVLA Group 2 standard, for the purpose of assessing their fitness to hold a private hire or hackney carriage drivers' licence. Existing drivers are required to undergo a medical every five years, or annually on renewal once they reach the age of 65. Additional more frequent medical assessment or tests may be required as advised by the council's medical adviser.

Group 2 Medical Standards

Medical standards for Group 2 are very much higher than those applied to Group 1, reflecting the high risk caused by the length of time the driver may spend at the wheel in the course of their occupation. (Group 1 includes motor cars and motor cycles.) The following conditions are a bar to meeting Group 2 standards:

1. Epilepsy or liability to epileptic attacks

A diagnosis of epilepsy or spontaneous epileptic attack(s) requires 10 years free of further epileptic attack without taking anti-epilepsy medication during that 10-year period.

2. Diabetes

Insulin Treated Diabetic drivers are now permitted to drive under current Group 2 standards. They are required to demonstrate good control of their condition and must satisfy the following criteria:

- no episode of hypoglycaemia requiring the assistance of another person has occurred in the preceding 12 months
- has full awareness of hypoglycaemia
- regularly monitors blood glucose at least twice daily and at times relevant to driving, (no more than 2 hours before the start of the first journey and every 2 hours while driving). More frequent testing may be required if for any reason there is a greater risk of hypoglycaemia, for example after physical activity or altered meal routine, using a glucose meter with a memory function to measure and record blood glucose levels. At the annual examination by an independent Consultant Diabetologist, the last 3 months of blood glucose readings must be available
- advised to use a modern blood glucose meter which has a memory chip
- must demonstrate an understanding of the risks of hypoglycaemia
- there are no other debarring complications of diabetes such as visual field defect
- if medical standards are met, a 1year licence will be issued

To obtain further information on Diabetes and the DVLA Group 2 medical standards of fitness to drive, please refer to the Diabetes section of the DVLA's publication 'At a Glance Guide to the Current Medical Standards of Fitness to Drive' and the Appendix to this chapter (INF188) at www.dvla.gov.uk/medical/ataglance

Non-Insulin Dependent Diabetics managed by tablets which carry a risk of inducing hypoglycaemia (this includes Sulphonylureas and Glinides) are also permitted to drive under current Group 2 standards. They are required to demonstrate good control of their condition and must satisfy the following criteria:

- no episode of hypoglycaemia requiring the assistance of another person has occurred in the preceding 12 months
- has full awareness of hypoglycaemia
- regularly monitors blood glucose at least twice daily and at times relevant to driving using a modern blood glucose meter which has a memory chip
- must demonstrate an understanding of the risks of hypoglycaemia
- there are no other debarring complications of diabetes, such as a visual field defect

If medical standards are met a 1, 2 or 3 year licence will be issued.

Please refer to the Diabetes section of the DVLA's publication 'At a Glance Guide to the Current Medical Standards of Fitness to Drive' at www.dvla.gov.uk/medical/ataglance and the appendix to that chapter (INF188/2).

Applicant's name _____ DOB: _____

3. Eyesight

The law requires that a licence holder or applicant must be able to meet the prescribed eyesight requirements, i.e. to read in good daylight (with the aid of glasses or contact lenses if worn) a registration mark fixed to a motor vehicle and containing letters and figures 79 millimetres high and 50 millimetres wide (i.e. post 1-9-2001 font) at a distance of 20 metres, or at a distance of 20.5 metres where the characters are 79 millimetres high and 57 millimetres wide (i.e. pre 1-9-2001 font).

In addition for group 2 entitlement drivers must have a visual acuity, using corrective lenses if necessary, of at least Snellen 6/7.5 (Snellen decimal 0.8) in the better eye and at least Snellen 6/60 (Snellen decimal 0.1) in the other eye. Where glasses are worn to meet the minimum standards, they should have a corrective power ≤ +8 dioptres in any meridian of either lens. It is also necessary for all drivers of Group 2 vehicles to be able to meet the prescribed Group 1 visual acuity requirements.

Normal binocular field of vision is required i.e. Any area of defect in a single eye is totally compensated for by the field of the other eye. Complete loss of vision in one eye or corrected acuity of less than 3/60 in one eye would be mean the applicant is barred from holding a Group 2 licence.

Grandfather rights apply in some instances regarding the above. To obtain further information on DVLA Group 2 medical standards of fitness to drive, please refer to the DVLA's publication 'At a Glance Guide to the Current Medical Standards of Fitness to Drive' at www.dvla.gov.uk/medical/ataglance or 0870 600 0301.
An applicant (or existing licence holder) failing to meet epilepsy, diabetes or eyesight regulations must be refused by law.

4. Other Medical Conditions

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

- Within 6 weeks of: myocardial infarction, an episode of unstable angina, CABG or coronary angioplasty.
- Angina, heart failure or cardiac arrhythmia which remain uncontrolled.
- Implanted cardiac defibrillator.
- Hypertension where the blood pressure is persistently 180 systolic or more and/or 100 diastolic or more.
- A stroke or TIA within the last 12 months.
- Unexplained loss of consciousness with liability to recurrence.
- Meniere's, or any other sudden and disabling vertigo within the past 1 year, with a liability to recurrence.
- Insuperable difficulty in communicating by telephone in an emergency.
- Major brain surgery and/or recent severe head injury with serious continuing after effects.
- Parkinson's disease, multiple sclerosis or other chronic neurological disorders with symptoms likely to affect safe driving.
- Psychotic illness, within the past 3 years.
- Serious psychiatric illness.
- If major psychotropic or neuroleptic medication is being taken.
- Alcohol and/or drug misuse within the past 1 year or alcohol and/or drug dependency in the past 3 years.
- Dementia.
- Any malignant condition, within the last 2 years, with a significant liability to metastasise (spread) to the brain.
- Any other serious medical condition likely to affect the safe driving of a medium/large goods or passenger carrying vehicle.

5. Tiredness: Sleep Disorders

Up to one fifth of accidents on motorways and other monotonous roads may be caused by drivers falling asleep at the wheel.

Applicant's name		DOB:	

Many accidents are attributed to “driver inattention” but once vehicle faults, traffic offences, poor road or weather conditions, alcohol and specific medical causes are excluded, closer inspection suggests driver sleepiness may be the cause. Evidence for this includes the apparent failure to respond to traffic and road conditions generally and, in particular, the absence of signs of emergency braking.

Driver sleepiness may be caused by modern life styles preventing adequate rest. It may be made worse by shift working combined with the monotonous nature of certain types of driving. Alertness fluctuates naturally throughout the day. Driving between 2am and 7am increases the risk of a sleep related accident. Most people also tend to be less alert during the mid-afternoon or after a heavy meal. All drivers need to address these problems responsibly.
However, some medical conditions may cause excessive sleepiness. These will greatly increase any normal tendency to sleepiness.

The most common medical cause is **OBSTRUCTIVE SLEEP APNOEA SYNDROME (OSA)**. This condition occurs most commonly, but not exclusively, in overweight individuals, particularly those with a large neck size. Partners often complain about the snoring and notice that sufferers seem to have irregular breathing during sleep. Sufferers of OSA rarely wake from sleep feeling fully refreshed and tend to fall asleep easily when relaxing.

OSA is one of the few medical conditions that has been shown to increase significantly the risk of traffic accidents. However, once diagnosed, there is very effective treatment available, normally through specialist centres. The greatest danger is prior to diagnosis, when the significance of the symptoms is not appreciated. A road traffic accident may be the first clear indication of the condition. All drivers, especially professional drivers, and doctors need to be much more aware of the risks of sleepiness from this treatable cause.

To obtain further information on DVLA Group 2 medical standards of fitness to drive, please refer to the DVLA’s publication ‘At a Glance Guide to the Current Medical Standards of Fitness to Drive’ at www.dvla.gov.uk/medical/ataglance or 0870 600 0301.

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MEDICAL EXAMINATION REPORT

Guidance Notes for the Doctor for completing the report

Before completing this form, please read information and useful notes (pages 2 and 3).

It may be helpful to consult DVLA's 'At A Glance Guide' (to the Current Medical Standards of Fitness to Drive). This is available for download at www.dvla.gov.uk/medical/ataglance.

Doctors may enquire in writing, or may speak to one of the medical advisers during office hours, to seek advice about a particular driver or about fitness to drive in general. After hours there is an answer phone.

Further help may be obtained by telephoning 01792 761119 (medical professionals only) and asking to speak to one of the Medical Advisers. Alternatively, enquiries can also be sent to medadviser@dvla.gsi.gov.uk, or to:

The Medical Adviser
Drivers Medical Group
DVLA
Longview Road
Morriston
SWANSEA SA99 1TU

DVLA will need to know the applicant's full name, address and date of birth.

Applicants who may be symptom-free at the time of the examination should be advised that if, in the future, they develop symptoms of a conditions which could affect safe driving they must inform the Licensing Department at hart District Council.

It is the duty of the licence holder or licence applicant to notify DVLA of any medical condition which may affect safe driving. If there are circumstances where the licence holder cannot, or will not, do so, the General Medical Council has issued clear guidelines to Doctors as to the appropriate action. The guidance is reproduced on Page 4 of the 'At A Glance' guide.

- The Medical Examination Report should be completed with reference to the applicant's medical history.
- Please answer **all** questions
- Please undertake a full examination of the patient. **This should include urine screening for Glucose.**
- Please make sure that you have printed the applicant's name and date of birth on each page before submitting this form

Applicant's name | DOB:

MEDICAL EXAMINATION REPORT

To be completed by the Doctor (please use black ink)

- Please answer **all** questions

Please give patient's weight and height — 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 sample positive for Glucose? **Yes** ☐ **No** ☐ **(please tick appropriate box)**

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

Current medication including exact dosage and reason for each treatment

Date when first licensed to drive a car _____ and/or taxi/private hire vehicle _____

Applicant's name _____ DOB: _____

Medical Examination Report for a Group 2 Licence

Do not complete the vision assessment until you have read the following

Important information for doctors

Please read and follow the information below before deciding if you are able to **fully** and **accurately** fill in the vision assessment. **If you are unable to do this, you must tell the applicant that they will need to ask an optician or optometrist to fill it in.**

We will make a licensing decision based on the information you provide.

What you need to assess

If glasses (not contact lenses) are worn for driving, you MUST be able to establish the dioptre measurement of the correction used. If the correction is greater than +8 dioptres in any meridian of either lens, we may not be able to issue a Group 2 licence.

Applicants for Group 2 entitlements must have, as measured by the 6 metre Snellen chart:

- a visual acuity of at least **6/7.5** (decimal Snellen equivalent 0.8) in the better eye
- a visual acuity of at least **6/60** (decimal Snellen equivalent 0.1) in the other eye
- this may be achieved with or without glasses or contact lenses
- we cannot accept a Snellen reading shown with a plus (+) or minus (-) eg 6/6-2 or 6/9+3
- 3 metre readings must be converted to the 6 metre equivalent

Note: Drivers first licensed to drive Group 2 vehicles before 31 December 1996 who cannot meet the above standards may still be considered by DVLA on an individual basis. Please see leaflet INF4D (Medical examination report) for further information.

Before you fill in this report please:

- check the applicant's identity
- read the information leaflet INF4D (Medical examination report). This can be viewed in PDF format at **www.gov.uk/reapply-driving-licence-medical-condition**

The applicant is responsible for any fee payable for completion of the assessment. DVLA will not be liable for any costs involved.

Please note that if you complete the vision assessment as well as the medical assessment, you must sign and date **both** parts of the form.

Applicant's name | DOB:

MEDICAL EXAMINATION REPORT

Vision assessment

To be filled in by a doctor or optician/optometrist
You MUST read the guidance notes on page 2 before completing this report

Vision (please see Eyesight notes on page 2)

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. 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** ☐

3. Were corrective lenses worn to meet this standard? **YES** ☐ **NO** ☐

If **Yes**, glasses ☐ contact lenses ☐ both together ☐

4. Pleae state the visual acuity of each eye. Please convert any 3 metre readings to the 6 metre equivalent.

Uncorrected		**Corrected (using the prescription worn for driving)**	
R	L	R	L

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? If No, please give gull details in the Box provided. **YES** ☐ **NO** ☐

If you answer yes to any of the following, give 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** ☐

If formal visual field testing is considered necessary, DVLA will commison this at a Later date.

8. Is there diplopia? **YES** ☐ **NO** ☐

(a) 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 opthalmic condition? **YES** ☐ **NO** ☐

Applicant's name _____ DOB: _____

Details/additional information

Date of eyesight examination if different to date of signature D D M M Y Y

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

Applicant's name DOB:

1 Nervous System

Questions 1-4 below MUST be answered.
Please tick ✓ the appropriate box(es)

		YES	NO
1.	Has the applicant had any form of seizure?	☐	☐
	If **NO**, please go to **question 2 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 complete current medication on page 5 of this form.		
	(d) If no longer treated, please give date when treatment ended. ☐☐☐☐☐☐		
	(e) Has the applicant had a brain scan?	☐	☐
	If **YES**, please give details in **Section 6**		
	(f) Has the applicant had an EEG?	☐	☐
	If **YES** to any of above, please supply reports if available.		

		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 6**		

3.	Does the applicant suffer from narcolepsy/cataplexy?	☐	☐
	If **YES**, please give details in **Section 6**		

		YES	NO
4.	**Is there a history of, or evidence of, any of the conditions listed at a-h below?**		
	If NO, go to **Section 2.**	☐	☐
	If YES, please tick the relevant box(es) and give dates and full details at **Section 6** and supply relevant reports**.**		
	(a) Stroke/TIA	☐	☐
	If **YES**, please give date ☐☐☐☐☐☐		
	Has there been a **full** recovery?	☐	☐
	Has a carotid ultra sound been undertaken?	☐	☐
	(b) Sudden and disabling dizziness/vertigo within the last year with a liability to recur	☐	☐
	(c) Subarachnoid haemorrhage	☐	☐
	(d) Serious head injury within the last 10 years	☐	☐
	(e) Any form of brain tumour, either benign or malignant, primary or secondary	☐	☐
	(f) Other brain surgery or abnormality	☐	☐
	(g) Chronic neurological disorders	☐	☐
	(h) Parkinson's disease	☐	☐

2 Diabetes Mellitus

		YES	NO
1.	**Does the applicant have diabetes mellitus?**		
	If NO, please proceed to **Section 3.**	☐	☐
	If YES, please answer the following questions.		
2.	Is the diabetes managed by:-	☐	☐
	(a) Insulin?		
	If **YES**, please give date started on insulin ☐☐☐☐☐☐		
	(b) Have you examined his/her blood glucose record for the last 6 continuous weeks from a memory meter(s)?	☐	☐
	If **NO**, please give details in **Section 6**		

Applicant's name _____ DOB: _____

		Yes	No
(c)	Other injectable treatments?	☐	☐
(d)	A Sulphonylurea or a Glinide?	☐	☐
(e)	Oral hypoglycaemic agents and diet?	☐	☐
	If **YES** to any of a-e, please complete current medication on the appropriate section on the front of this form		
(f)	Diet only?	☐	☐

3.	(a) Does the patient 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:-	**Yes**	**No**
	(a) Loss of visual field?	☐	☐
	(b) Severe peripheral neuropathy, sufficient to impair limb function for safe driving?	☐	☐
	If **YES**, to any of 4-6 above, please give details in **Section 6**		

7.	Has there been laser treatment or intra-vitreal treatment for retinopathy?	☐	☐
	If **YES**, please give date(s) of treatment		

3 Psychiatric Illness

All questions must be answered

- **Please enclose relevant hospital notes**

	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 4**

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 6.**

NB. If applicant remains under specialist clinic(s) ensure details are completed at the top of page 1.

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 dependency in the past 3 years	☐
6.	Persistent drug misuse in the past 12 months	☐
7.	Drug dependency in the past 3 years	☐

If yes to ANY of questions 4-7, please state how long this has been controlled

Applicant's name DOB:

Please give details of past consumption or name of drug(s) and frequency

4 Cardiac

Please follow the instructions in all Sections (4A-4G) giving details as required at Section 6 and enclose hospital notes relevant to this condition.

NB. If applicant remains under specialist cardiac clinic(s) ensure details are completed at the top of page 5 and Sections 4F and 4G.

4A Coronary Artery Disease

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

If **NO**, proceed to **Section 4B**

If **YES**, please answer all questions below and give details at **Section 6** of the form and enclose relevant hospital notes.

1. Has the applicant suffered from angina? ☐ ☐

If **YES**, please give the date of the last known attack ☐☐☐☐☐☐

2. Acute coronary syndrome including myocardial infarction? ☐ ☐

If **YES**, please give date(s) ☐☐☐☐☐☐

3. Coronary Angioplasty (PCI? ☐ ☐

If **YES**, please give date of most recent intervention ☐☐☐☐☐☐

4. Coronary artery by-pass graft surgery? ☐ ☐

If **YES**, please give date(s) ☐☐☐☐☐☐

4B Cardiac Arrhythmia

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

If **NO**, proceed to **Section 4C**

If **YES**, please answer all questions below and give details at **Section 6** of the form**.**

1. Has there been a significant disturbance of cardiac rhythm? Ie Sinoatrial disease, Significant atrial-ventricular conduction defect, atrial flutter/fibrillation, narrow or broad Complex tachycardia in the last 5 years? ☐ ☐

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

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

4. Has a pacemaker been implanted? ☐ ☐

If **YES**:-

(a) Please supply date of implantation ☐☐☐☐☐☐

(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

Is there a history of or evidence of **ANY** of the following: YES ☐ NO ☐

If **NO**, go to **Section 4d**

Applicant's name _____ DOB: _____

If **YES**, please answer all questions below and give details in **Section 6.**

		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? 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** >5.5cm? If **NO**, please provide latest measurement and date obtained:	☐ ☐ ☐	☐ ☐ ☐
4.	Dissection of the aorta repaired successfully 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? If YES, provide relevant hospital notes	☐	☐

4D Valvular/Congenital Heart Disease

		YES	NO
	Is there a history of, or evidence, of valvular/congenital heart disease? If **NO**, proceed to **Section 4E** If **YES**, please answer all questions below and give details at **Section 6** of the form**.**	☐	☐
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? If **YES**, please provide relevant reports	☐	☐
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

		YES	NO
	Does the applicant have a history of ANY of the following conditions: If **NO**, go to **Section 4f** If **YES**, please answer **ALL** questions and give details in **Section 6**	☐	☐
(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?	☐	☐

Applicant's name _____ DOB: _____

(e) Untreated atrial myxoma?

4F Cardiac Investigations

All questions must be answered

		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***		
2.	Has an exercise ECG been undertaken (or planned)?	☐	☐
	If **YES**, please give date ☐☐☐☐☐☐ and give details in **Section 6**		
	Sight/copy of the exercise test result/report (if done in the last 3 years) would be useful		
3.	Has an echocardiogram been undertaken (or planned)?	☐	☐
	(a) If **YES**, please give date ☐☐☐☐☐☐ and give details in **Section 6**		
	(b) If undertaken, is/was the left ejection fraction greater than or equal to 40%	☐	☐
	Sight/copy of the echocardiogram result/report would be useful		
4.	Has a coronary angiogram been undertaken (or planned)?	☐	☐
	If **YES**, please give date ☐☐☐☐☐☐ and give details in **Section 6**		
	Sight/copy of the angiogram result/report would be useful		
5.	Has a 24 hour ECG tape been undertaken (or planned)?	☐	☐
	If **YES**, please give date ☐☐☐☐☐☐ and give details in **Section 6**		
	Sight/copy of the 24 hour tape result/report would be useful		
6.	Has a myocardial perfusion scan or stress echo study been undertaken (or planned)?	☐	☐
	If **YES**, please give date ☐☐☐☐☐☐ and give details in **Section 6**		
	Sight/copy of the scan result/report would be useful		

4G Blood Pressure

1. Please record today's blood pressure reading? ☐

		Yes	No
2.	Is the applicant on anti-hypertensive treatment?	☐	☐

If **YES**, provide three previous readings with dates if available

☐ ☐☐☐☐☐☐

☐ ☐☐☐☐☐☐

☐ ☐☐☐☐☐☐

Applicant's name ☐ DOB: ☐

5 General

Please answer all questions in this section. If your answer is 'YES' to any of the questions, please give full details in Section 6.

1. MUSCULOSKELETAL SYSTEM

Normally the Licensing Authority requires full functioning of spine and all 4 limbs for the granting of a licence.

		YES	NO
a)	Has the applicant a significant disability of the spine which is likely to interfere with the efficient discharge of his/her duties as a vocational driver.	☐	☐
b)	Has the applicant any deformity, loss of limbs or parts of limbs, or physical disability (with special attention paid to the condition of the arms, legs, hands and joints) which is likely to interfere with the efficient discharge of his/her duties as a vocational driver?	☐	☐

2. Is there currently any functional impairment that is likely to affect control of the vehicle? ☐ ☐

3. Is there a history of bronchogenic carcinoma or other malignant tumour with a significant liability to metastasise cerebrally? ☐ ☐

4. Is there any illness that may cause significant fatigue or cachexia that affects safe driving? ☐ ☐

5. 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, eg a text phone? ☐ ☐

6. Does the applicant have a history of liver disease of any origin? ☐ ☐

If **YES**, please give details in **Section 6**

7. Is there a history of renal failure? ☐ ☐

If **YES**, please give details in **Section 6**

8. 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 give diagnosis: ☐

Please give:

(a) Date of diagnosis ☐☐☐☐☐☐

(b) Is it controlled successfully? ☐ ☐

(c) If **YES**, please state treatment ☐

(d) Please state period of control ☐

(e) Date last seen by consultant ☐☐☐☐☐☐

9. Does the applicant have severe symptomatic respiratory disease causing chronic hypoxia? ☐ ☐

10. Does any medication currently taken cause the applicant side effects that would affect safe driving? ☐ ☐

If **YES**, please provide details of medication and symptoms in **Section 6**

11. Does the applicant have an ophthalmic condition? ☐ ☐

If **YES**, please provide details in **Section 6**

12. Does the applicant have any other medical condition that could affect safe driving? ☐ ☐

Applicant's name ☐ DOB: ☐

If **YES**, please provide details in **Section 6**

6 Further Details

Please use the space below to provide further details required with reference to any of the previously answered questions.
Please forward copies of all relevant hospital notes if available.

7 Consultants' details

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

Consultant in:
Name:
Address:

Date of last appointment: | | | | | | | |

Consultant in:
Name:
Address:

Date of last appointment: | | | | | | | |

Applicant's name | | DOB: | |

Consultant in:
Name:
Address:

Date of last appointment: | | | | | | |

8 Medication

Please provide details of all current medication (continue on a separate sheet if necessary)

Medication	
Reason for taking:	

Medication	**Dosage**
Reason for taking:	

Medication	**Dosage**
Reason for taking:	

Medication	**Dosage**
Reason for taking:	

9 Additional information

Patient's weight (kg)	
Height (cms)	
Details of smoking habits, if any	
Number of alcohol units taken each week	

Examining Doctor's details

To be filled in by doctor carrying out the examination

Please ensure all sections of the form have been completed.
Failure to do so will result in the form being rejected.

10 Doctor's details (please print name and address in capital letters)

Name:
Address:
Telephone:
Email address:
Fax Number:

Surgery stamp

I confirm that this report was completed at examination and that I am currently GMC registered and licensed to practice medicine within the EU, if the report was completed outside of the UK.

I hereby certify that I have today examined the above named applicant and that:

- **the applicant is registered at this medical practice**
- **the applicants medical notes were seen and checked whilst I carried out the medical examination**
- **to the best of my knowledge and belief, the answers to the foregoing questons are true and correct.**

GMC Registration Number

Signature of Medical Practitioner

Date of examination:

If you have filled in both the vision and medical assessments, both sections must be signed and dated.

Applicant's name DOB:

Applicant's details

To be filled in in the presence of the doctor 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.

11 Your details

Your full name:
Your address:
Email address:

Date of birth: | | | | | | | | |

Home phone number:

Work/daytime number:

Date when first licensed to drive a hackney carriage or private hire vehicle

About your doctor/group practice

Doctor/group name:
Address:
Telephone:
Email address:
Fax Number:

Applicant to return this form to the **Shared Licensing Service** at:

Basingstoke and Deane Borough Council

Civic Offices

London Road

Basingstoke

Hampshire

RG21 4AH

Applicant's name DOB: