Medical Report
Associated with a Drivers Licence

- Town Police Clauses Act 1847
- Local Government (Miscellaneous Provisions) Act 1976
- Read in conjunction with Lewes District Council's Byelaws and Licensing Policy

Lewes District Council

MEDICAL IN CONFIDENCE

You MUST have this Medical Report form completed by a Doctor *(usually your GP)*, who has access to your current medical records.

WHAT DO YOU HAVE TO DO

If you have any doubts about your ability to undertake the role of a Hackney Carriage or Private Hire driver, consult your Doctor/ Optician for advice **BEFORE** you arrange for this medical form to be completed as the Doctor will normally charge you for completing it.

Complete **Section 1 & 2** (Page 3 & 4) of this report in the presence of the Doctor carrying out the examination.

If you have any queries, please telephone the Licensing Section on 01273 471600 or send an email to licensing@lewes-eastbourne.gov.uk.

Please remove pages 1 & 2 before sending in the completed form at **Step Three** of your application process (outlined in Guidance for New Applicants) and check that all the sections have been completed fully.

If, in future, you develop symptoms of a condition which could affect safe driving and you hold any type of driving licence, you must inform the Drivers Medical Group (*DVLA, Longview Road, Swansea SA99 1TU*) and Lewes District Council's Licensing Section.

WHAT THE DOCTOR HAS TO DO

Please arrange for the patient to be seen and a full examination to be undertaken.

Please complete Sections 3–10 of this report. You may find it helpful to consult the DVLA's "At a Glance" booklet available at www.gov.uk/current-medical-guidelines-dvla-guidance-for-professionals-conditions-a-to-c.

Please ensure you authenticate each page (where indicated) of this document to confirm that the record in question relates to the patient you are assessing.

Please ensure that you have completed all the sections including consultant/ specialist details where appropriate and your surgery/ practice stamp.

Every effort should be made to establish medical history when completing this form. If this report does not bring out important clinical details with respect to driving, please give details in Section 9.

Applicants who may be symptom free 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 Drivers Medical Group, Longview Road, Swansea SA99 1TU and Lewes District Council.

Medical Examination Report

SECTION ONE: Information about the Applicant

To be completed by the applicant (Please use black ink)

Title (Please Circle) **Mr / Mrs / Miss / Ms / Mx**
Other (Please Specify)

Surname / Family Name
Forename(s)

Home Address

Postcode **Date of Birth**

Home Telephone No:

Work/ Daytime No:

Mobile Telephone Number

Email Address

Please give the name & address of your GP

Name of GP

Address

Postcode **Telephone No**

Email Address

Please give the name, address & speciality of any consultant you are currently under

Consultant's Name
Speciality

Home Address

Postcode **Telephone No**

Email Address

<u>SECTION TWO</u>: Applicant's Consent & Declaration

This Section must be completed and must not be altered in any way

Please sign statements below.

I authorise my Doctor(s) and Specialist(s) to release reports to Officers at Lewes District Council about my medical condition(s).

I authorise Lewes District Council to divulge relevant medical information about me to Doctors or Paramedical staff, as necessary, in the course of medical enquiries into my fitness to drive.

I declare that I have checked the details I have given on the enclosed questionnaire and that to the best of my knowledge it is correct.

Signature | | Date | |

I authorise Lewes District Council to release medical information to my Doctor(s) and/or Specialist(s) about the outcome of my case. (This is to enable your Doctor to advise you about fitness to drive).

Signature | | Date | |

NOTE ABOUT CONSENT

You will see that we have asked for your consent, not only for the release of medical reports from your doctors, but also that we very occasionally release medical information to Doctors or Paramedical staff, either because we wish you to examined and the doctors need to know the medical details, or because we require further information

SECTION THREE: Medical Examination Report

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

Please answer all questions using Group 2 Medical Standards

Weight (kg/st)		Height (cm/ft)	

Give details of smoking habits, if any

Number of alcohol units consumed each week

Details of specialist(s) / Consultant(s)

	1	2	3
Speciality			
Date last seen			
Current Medication			

SECTION FOUR: Vision

If you do not have the equipment to carry out these checks, then you should refer the applicant to an ophthalmic specialist or optician.

	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 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 ☐

4.	**Is there a full binocular field of vision?** (Central and peripheral) If **NO**, and there is a visual field defect, please give details in **SECTION 10** and enclose a copy of recent field charts, if possible.	☐	☐
5.	Is there diplopia? (controlled or uncontrolled) If **YES**, please give full details of method of control in **SECTION 10**	☐	☐
6.	Has the applicant had a cataract removed? If **YES**, please give full details in **SECTION 10**	☐	☐
7.	Does the applicant have any other ophthalmic condition? If **YES**, please give details in **SECTION 10**	☐	☐

<u>SECTION FIVE</u>: Nervous System

	Please tick the appropriate box(es)	**YES**	**NO**
1.	Has the applicant ever had any form of epileptic attack?	☐	☐
	a) If **YES**, please give date of last attack		
	b) If treated, please give date when treatment ceased		
2.	Is there a history of blackouts or impaired consciousness within the last 5 years? If **YES**, please give date(s) and details in **SECTION 10**	☐	☐
3.	Does the applicant suffer from narcolepsy/ cataplexy? If **YES**, please give details in **SECTION 10**	☐	☐
4.	**Is there a history of, or evidence of any of the conditions listed at a-h below?** If **NO**, please move onto SECTION SIX If **YES**, please tick the relevant box(es) and give dates and full details in **SECTION 10**	☐	☐

a) Stroke/ TIA (please delete as appropriate) ☐
b) Sudden and disabling dizziness/ vertigo within the last year ☐
c) Subarachnoid haemorrhage ☐
d) Serious head injury ☐
e) Brain tumour, either benign or malignant, primary or secondary ☐
f) Other brain surgery ☐
g) Chronic neurological disorders ☐
h) Dementia or cognitive impairment ☐

SECTION SIX: Diabetes Mellitus

	Please tick the appropriate box(es)	YES	NO
1.	**Does the applicant have diabetes mellitus?**	☐	☐

If **YES**, please answer the following questions
If **NO**, please move onto SECTION SEVEN

2. Is the diabetes managed by:
   a) Insulin ☐
   b) Oral hypoglycaemic agents and diet ☐
   c) Diet only ☐

   If controlled by medication, please provide date commenced ☐

3.	Does the applicant regularly test blood glucose?	☐	☐
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 for 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 a third party?	☐	☐

If **YES** to ANY of 4-6 above, please give details in **SECTION 10**

SECTION SEVEN: Psychiatric Illness

	Please tick the appropriate box(es)	YES	NO
1.	**Is there a history of, or evidence of any of the conditions listed at 1 – 6 below?**	☐	☐

If **NO**, please move onto SECTION 8
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 10**

NB If the applicant remains under specialist clinic(s) please ensure details are completed in SECTION 1

a) Significant psychiatric disorder within the past 6 months ☐
b) A psychotic illness within the past 3 years ☐
c) Persistent alcohol misuse in the past 12 months ☐
d) Alcohol dependency in the past 3 years ☐
e) Persistent drug misuse in the past 12 months ☐
f) Drug dependency in the past 3 years ☐

SECTION EIGHT: Cardiac

Please follow the instructions in all Sections (8A – 8G) giving details as required at SECTION 11. NB If the applicant remains under specialist cardiac clinic(s) ensure details are complete on SECTION 1.

SECTION EIGHT (A): Coronary Artery Disease

	Please tick the appropriate box(es)		**YES**	**NO**
1.	**Is there a history of, or evidence of, coronary artery disease?** If **NO**, please move onto SECTION 8(B) If **YES**, please answer all questions below and give full details in SECTION 10 of this form		☐	☐
	1. Myocardial infraction? *If **YES**, please give date(s)*		☐	☐
	2. Coronary artery by-pass graft? *If **YES**, please give date(s)*		☐	☐
	3. Coronary Angioplasty (with or without stent)? *If **YES**, please give date(s)*		☐	☐
	4. Has the applicant suffered from Angina? *If **YES**, please give date of the last attack*		☐	☐

Please proceed to Section 8(B)

SECTION EIGHT (B): Cardiac Arrhythmia

	Please tick the appropriate box(es)	YES	NO
1.	**Is there a history of, or evidence of cardiac arrhythmia?**	☐	☐

If **NO**, proceed to Section 8(C)
If **YES**, please answer all questions below and give details at SECTION 10

1)	Has the applicant had a significant documented disturbance of cardiac rhythm within the past 5 years?	☐	☐
2)	Has the arrhythmia been controlled satisfactorily for at least 3 months?	☐	☐
3)	Has a cardiac defibrillator device been implanted?	☐	☐
4)	Has a pacemaker been implanted?	☐	☐

If **YES**

a)	Has the pacemaker been implanted for at least 6 weeks?	☐	☐
b)	Since implantation, is the patient now symptom free from this condition?	☐	☐
c)	Does the applicant attend a pacemaker clinic regularly?	☐	☐

Please proceed to Section 8(C)

SECTION EIGHT (C): Peripheral Arterial Disease

	Please tick the appropriate box(es)	YES	NO
1.	Is there a history of evidence of ANY of the following?	☐	☐

If **YES**, please tick ALL relevant boxes below and give full details in SECTION 10 of this form

	PERIPHERAL ARTERIAL DISEASE	☐	☐
	AORTIC ANEURYSM	☐	☐

If **YES**, please answer the following

a)	Site of Aneurysm	Thoracic	☐	Abdominal	☐
b)	Has it been repaired successfully?		☐		☐
c)	Is the transverse diameter more than 5cms?		☐		☐

DISSECTION OF THE AORTA ☐ ☐

If **YES**, please answer the following

a) Has it been repaired successfully? ☐ ☐

Please proceed to Section 8(D)

SECTION EIGHT (D): Valvular/ Congenital Heart Disease

	Please tick the appropriate box(es)	**YES**	**NO**
1.	**Is there a history of, or evidence of valvular/ congenital heart disease?**	☐	☐

If **NO**, proceed to Section 8(E)
If **YES**, please answer all questions below and give details at SECTION 10

1)	Is there a history of congenital heart disease?	☐	☐
2)	Is there a history of heart valve disease?	☐	☐
3)	Is there a 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 Section 8(E)

SECTION EIGHT (E): Cardiomyopathy

	Please tick the appropriate box(es)	**YES**	**NO**
1.	**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 11.
If NO, proceed to SECTION 8(F)

SECTION EIGHT (F): Cardiac Investigations

This section must be completed for all applicants

Please tick the appropriate box(es)	**YES**	**NO**
1. Has a resting ECG been undertaken?	☐	☐
*If **YES**, does it show:*		
a) Pathological Q waves?	☐	☐
b) Left bundle branch block?	☐	☐
2. Has an exercise ECG been undertaken (or planned)?	☐	☐

*If **YES**, please give date*

Please provide full details in SECTION 10 and where possible provide a copy of the exercise test/report.

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

*If **YES**, please give date*

Please provide full details in SECTION 10 and where possible provide a copy of the echocardiogram result/ report.

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

*If **YES**, please give date*

Please provide full details in SECTION 10 and where possible provide a copy of the angiogram result/ report.

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

*If **YES**, please give date*

Please provide full details in SECTION 10 and where possible provide a copy of the 24-hour tape result/ report.

6. Has a myocardial perfusion imaging scan been undertaken (or planned)?	☐	☐

*If **YES**, please give date*

Please provide full details in SECTION 10 and where possible provide a copy of the scan result/ report.

Please proceed to Section 8(G)

SECTION EIGHT (G): Blood Pressure

Please tick the appropriate box(es)	YES	NO
1. Is today's systolic pressure greater than 180?	☐	☐
2. Is today's diastolic pressure greater than 100?	☐	☐
3. Is the applicant on anti-hypertensive treatment?	☐	☐
If **YES**, please supply today's reading		

SECTION NINE: General

Please answer all questions in this section.

If you answer YES, please give full details in SECTION 10

Please tick the appropriate box(es)	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 details and diagnosis and state whether there is current evidence of dissemination.		
3. 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. MINICOM/ text phone)?	☐	☐
4. Is there a history of either renal or hepatic failure?	☐	☐
5. Does the applicant have sleep apnoea syndrome?	☐	☐
If **YES**, has it been controlled successfully?	☐	☐

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

If **YES**, please give full details below.

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

8. Does any medication currently taken by the applicant, cause them any side effects which may impair their driving? ☐ ☐

*If **YES**, please provide full details in SECTION 10*

SECTION TEN: General

Please remember to complete SECTION 10 if you have answered YES to any question.

SECTION ELEVEN: Medical Practitioner Details

To be completed by the Doctor carrying out the examination

	YES	NO
Do you have access to at least 2 years Medical records for the applicant ?	☐	☐

If the answer is **NO**, please give details of previous registered Medical Practitioner.

Name	
Address	

I certify that the applicant has had a Group 2 Medical Examination and in my professional opinion the applicant, who seeks to obtain a licence to transport members of the public in a licensed vehicle is…

FIT ☐ **UNFIT** ☐

Please provide details of the surgery who undertook this examination

Name	
Address	

Surgery Stamp

Signature of Medical Practitioner

Date

GP Number

Please return the completed form to:
Lewes District Council Licensing Section,
6 High Street, Lewes, East Sussex
BN7 2AD