Taxi Medical Examination Report

To be filled in by the applicants own GP or other qualified doctor. The applicant must fill in sections 16 and 17.
The doctor should fully examine the patient as well as taking the patient's history and answer **all** questions

1 Details of specialist /consultants, including address (if relevant to DVLA group 2 medical standards)

Date of last appointment

medication	dosage	reason taken

2 Vision

A medical standard of at least 6/60 in the worst eye, and 6/7.5 in the better eye is normally required

	YES	NO
1. Does the patient's vision reach this standard without glasses or contact lenses?	☐	☐
2. If no, does the patient's vision reach this standard with glasses or contact lenses?	☐	☐
(c) If correction is required to meet the above standard, is it is well tolerated?	☐	☐

3. 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 Right ☐ Left ☐ **Corrected** (if applicable) Right ☐ Left ☐

Note 1: It is not necessary to record the uncorrected acuity if the patient requires glasses or contact lenses to reach the above standard.

Note 2: In exceptional circumstances a person who has held a licence for many years may be permitted to hold a licence with vision which fails to meet the above acuity standards. The examining doctor is advised to consult the DVLA publication "Assessing fitness to Drive" or seek further guidance in these cases.

A patient must not require spectacles which have lenses of +8 dioptres or greater.

4. Does the patient require spectacles of +8 dioptres or greater to meet the above visual acuity requirement? ☐ ☐
Note 3: It may be necessary for the patient to obtain a declaration from an optometrist to confirm this.

5. Is there a defect in the patient's binocular field of vision (central and/or peripheral)? ☐ ☐

6. Is there diplopia? (controlled or uncontrolled)? ☐ ☐

7. Does the patient have any other ophthalmic condition? If **YES** to 4, 5 or 6, please give details in **Section 14** ☐ ☐

Patient's name ☐ **Date of birth** ☐

3 Nervous system

1. Has the patient had any form of epileptic attack? **YES** ☐ **NO** ☐
If **YES**, please answer questions a–f If NO go to question 2

(a) Has the patient had more than one attack? **YES** ☐ **NO** ☐

(b) Please give date of first and last attack

First attack ☐ Last attack ☐

(c) Is the patient currently on anti-epilepsy medication? **YES** ☐ **NO** ☐
If **Yes,** please fill in current medication on the appropriate section on the front of this form

(d) If no longer treated, date when treatment ended ☐

(e) If the patient has had a brain scan**,** please state:

MRI ☐ Date ☐ CT ☐ Date ☐

(f) Has the patient had an EEG? If Yes please give date ☐

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 14**

3. Is there a history of, or evidence of, any of the conditions listed at a–g below? ☐ ☐
If **NO,** go to **Section 4.**
If **YES,** give dates and full details at **Section 14**.

	YES	NO
(a) Stroke or 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 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 or abnormality	☐	☐
(g) Chronic neurological disorders e.g. Parkinson's disease, multiple sclerosis	☐	☐

4 Diabetes

1. Does the patient have diabetes mellitus? ☐ ☐
If **NO,** please go to **Section 5.** If **YES,** please answer the following questions.

2. Is the diabetes managed by:-	YES	NO
(a) Insulin?	☐	☐
(b) Other injectable treatments?	☐	☐
(c) A sulphonylurea or a glinide?	☐	☐
(d) Oral hypoglycaemic agents and diet?	☐	☐
(e) Diet only?	☐	☐

3. ***This question does not need to be answered unless the applicant takes insulin or sulphonylurea or glinide***

(a) Does the patient test blood glucose less than two hours before starting driving duties and then every two hours whilst driving?	☐	☐
(b) Does the patient test at times relevant to driving?	☐	☐
(c) Does the patient carry fast acting carbohydrate in the vehicle when driving?	☐	☐
(d) Does the patient have an adequate understanding of diabetes and the necessary precautions for safe driving?	☐	☐

Patient's name ☐ **Date of birth** ☐

	YES	NO
4. Is there evidence of:- (a) Loss of visual field?	☐	☐
(b) Severe peripheral neuropathy, sufficient to impair limb function for safe driving?	☐	☐
5. Is there any evidence of impaired awareness of hypoglycaemia?	☐	☐
6. Has there been laser treatment for retinopathy or intra-vitreal treatment for retinopathy? If **YES**, please give date(s) of treatment	☐	☐
7. Is there a history of hypoglycaemia in the last 12 months requiring the assistance of another person?	☐	☐

If **YES** to any of 4–7 above, please give details in **Section 14**

5 Psychiatric illness and substance misuse

	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 6** 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 14.**	☐	☐

If patient remains under specialist clinic(s), ensure details are given.

	YES	NO
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 dependence in the past 3 years	☐	☐
6. Persistent drug misuse in the past 12 months	☐	☐
7. Drug dependence in the past 3 years	☐	☐

6 Coronary artery disease

	YES	NO
Is there a history of, or evidence of, coronary artery disease? If **NO,** go to **Section 7**	☐	☐

If **YES,** answer all questions below and give details at **Section 14**.

	YES	NO
1. Acute coronary syndromes 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 patient suffered from angina? If **YES**, please give the date of the last known attack	☐	☐

Patient's name ☐ **Date of birth** ☐

7 Cardiac arrhythmia

Is there a history of, or evidence of, cardiac arrhythmia, or channelopathies including Brugada or long QT syndrome? YES ☐ NO ☐

If **NO**, go to **Section 8**
If **YES**, please answer all questions below and give details in **Section 14**.

	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 of implantation ☐

(b) Is the patient free of symptoms that caused the device to be fitted?	☐	☐
(c) Does the patient attend a pacemaker clinic regularly?	☐	☐

8 Peripheral arterial disease, aortic aneurysm/dissection

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

If **YES**, please **tick** ALL relevant boxes below, and give details in **Section 14**.
If **NO**, go to **Section 9**

	YES	NO
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? ☐		
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 aorta? If so give full details.	☐	☐

9 Valvular/congenital heart disease

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

If **NO**, go to **Section 10**
If **YES**, please answer all questions below and give details in **Section 14**.

	YES	NO
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 patient currently have significant symptoms?	☐	☐
5. Has there been any progression since the last licence application? (if relevant)	☐	☐

Patient's name ☐ **Date of birth** ☐

10 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 or heart/ lung transplant? (d) Untreated atrial myxoma	☐	☐

If YES, please give full details in Section 14 of the form. If NO, go to section 11

11 Cardiac investigations

If you answer yes to any of these questions please give relevant information in Section 14

	YES	NO
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 an exercise ECG been undertaken (or planned)?	☐	☐
If **YES**, please give date ☐		
3. Has an echocardiogram been undertaken (or planned)?	☐	☐
(a) If **YES**, please give date ☐		
(b) If undertaken, was the left ventricular ejection fraction at least 40%?	☐	☐
4. Has a coronary angiogram been undertaken (or planned)?	☐	☐
If **YES**, please give date ☐		
5. Has a 24 hour ECG tape been undertaken (or planned)?	☐	☐
If **YES**, please give date ☐		
6. Has a myocardial perfusion scan or stress echo study been undertaken (or planned)?	☐	☐
If **YES**, please give date ☐		

12 Blood pressure

	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?	☐	☐
Please give today's reading ☐		
3. Is there a history of malignant hypertension?	☐	☐
3. Is the patient on anti-hypertensive treatment?	☐	☐

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

☐ ☐ ☐

Patient's name ☐ **Date of birth** ☐

13 General

Please answer all questions in this section. If your answer is 'YES' to any of the questions, please give full details **in Section 14.**

	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	☐	☐
3. Is there any evidence the patient has a cancer that causes fatigue or cachexia that affects safe driving?	☐	☐
4. 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. a textphone? **YES** ☐ **NO** ☐	☐	☐
5. Does the patient have a history of alcoholic liver disease and/or liver cirrhosis of any origin? If **YES,** please give details in **Section 14**	☐	☐
6. Is there a history of, or evidence of, sleep apnoea syndrome? If **YES**, please provide details	☐	☐

(a) Date of diagnosis

(b) If yes, is it controlled successfully? **YES** ☐ **NO** ☐

(c) If **YES**, state treatment (d) Please state period of control

(e) Date last seen by consultant

7. Does the patient suffer from narcolepsy or cataplexy? If **YES,** please give details in **Section 14**	☐	☐
8. 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? **YES** ☐ **NO** ☐

(d) If **YES**, state treatment (e) State period of control

(f) Date last seen by consultant

9. Does the patient have severe symptomatic respiratory disease causing chronic hypoxia?	☐	☐
10. Does any medication currently taken cause the patient side effects that could affect safe driving? If **YES**, please provide details of medication and symptoms	☐	☐
Does the patient have any other medical condition that could affect safe driving? If **YES**, please provide details	☐	☐

Number of alcohol units taken each week

Patient's name **Date of birth**

14

Patient's name **Date of birth**

Medical Practitioner Details

To be filled in by Doctor carrying out the examination

15 **Please ensure all relevant sections of the form have been filled in as, if not, this will cause the form to be returned for completion**

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

Name
Address
Telephone

Surgery Stamp and GMC Registration Number

Signature of Medical Practitioner

Date of Examination

Applicant's Details

To be filled in before the examination

Please make sure that you have printed your name and date of birth on each page before the examination

16 Your details

Your full name	
Your address	
Email address (optional)	

Date of Birth | | | | | | | | |

Home phone number

Work/Daytime number

About your GP/group practice

Name of surgery or GP	
Address	
Phone (if known)	

17 Applicant's consent and declaration

This section **MUST** be filled in and must **NOT** be altered in any way.
Please read the following important information carefully then sign to confirm the statements below.

Important information about Consent
On occasion, as part of the investigation into your fitness to drive, the 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. I now authorise the doctor carrying out this assessment to inform the Council of my fitness to drive and to release medical information only to the extent which it is necessary for the Council to make decisions on my fitness and safety to work. I am aware that I can request sight of a report either before or after it is sent.

Consent and Declaration
I authorise my doctor(s) and specialist(s) to release reports/medical information about my condition relevant to my fitness to drive, to the Council Medical Advisor about my condition.

I authorise the Council to disclose such relevant medical information as may be necessary to the investigation of my fitness to drive, to doctors, paramedical staff and to release to my doctor(s) details of the outcome of my case and any relevant medical information.

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.

Name

Signature **Date**

TAXI DRIVERS - MEDICAL CERTIFICATE

Name of driver ..... Date of birth .....

☐ The applicant meets the DVLA group 2 medical standard of fitness and is therefore fit to drive hackney carriage/private hire vehicles.

☐ The applicant does not meet the DVLA group 2 medical standard of fitness and is therefore not fit to drive hackney carriage/private hire vehicles.

☐ I have found a matter of relevance but I recommend that you do not revoke a current licence for the time being but that you note the following recommendations regarding further medical evidence:

- ☐ You should require the driver to produce, within six weeks, a written statement from his doctor stating that ***his blood pressure (on medical treatment if necessary) is not consistently above 180/100***.
- ☐ You should require the driver to produce, within two weeks, a written statement from an optometrist stating that ***his visual acuity, with glasses if necessary, is at least 6/7.5 in the better eye and 6/60 in the worse eye, using corrective lenses if necessary, and that any necessary spectacle lenses do not have a strength of greater than +8 dioptres.***
- ☐ You should require the driver to produce, within three months, a statement from his GP or hospital specialist stating that ***within the last three years he has had an exercise treadmill test or other equivalent test of cardiac function and that this demonstrates that he meets the DVLA group 2 standard***.
- ☐ You should require the driver to produce, within three months, a statement from his GP or hospital specialist stating that **he has had a cardiac scan which shows an ejection fraction (LVEF) of at least 40%.**
- ☐ The driver should produce to you, within six weeks, the form "*Medical statement for drivers with tablet-controlled diabetes*", duly completed by a medical practitioner and by himself. I have given the applicant a copy of this form.

  He should produce a statement from _____ within ___ weeks, stating: "_____

☐ The applicant has diabetes treated by insulin and should be considered fit and granted a licence once he has produced to you the form "*Medical statement for drivers with diabetes using insulin*", duly completed by a diabetes consultant and by himself. I have given the applicant a copy of this form. You should require a fresh version of this medical statement to be produced every 12 months.

Is there any reason to have a review before five years, or annually if over the age of 65?

☐ No, only as above ☐ Yes, more frequently If yes state what interval is recommended: _____

Doctor's signature.....

Doctor's name (please print).....

Date of examination.....

Surgery Stamp:

Notes for the examining doctor: Taxi and private hire drivers must achieve the same medical standard as DVLA group 2 (*Medical Aspects of Fitness to Drive*, The Medical Commission on Accident Prevention 1995; and *Fitness to Drive, A Guide for Health Professionals*, Tim Carter, Chief Medical Advisor to the Department for Transport, 2006)

If the applicant is applying for a new licence, the required medical standard must be met before the person can be certified as fit. If an applicant is renewing an existing licence, and the problem which is identified is not of immediate medical concern, such as blood pressure marginally above the DVLA group 2 level or visual acuities marginally worse than the DVLA group 2 level, the candidate should be considered to be a "provisionally fit" and allowed to hold a licence with appropriate instructions to the licensing authority as indicated above.

An applicant using insulin for diabetes must produce both a declaration from a diabetes consultant and a declaration signed by himself, confirming a satisfactory level of control and monitoring as specified in the accompanying form " *Medical statement for drivers with diabetes using insulin*". He should not be considered fit to hold a licence until this is done.

An applicant taking sulphonylureas or glinides must produce both a declaration from a doctor and from himself confirming a satisfactory level of control and monitoring as specified in the accompanying form "*Medical statement for drivers with tablets-controlled diabetes*" but may be allowed a period of grace to obtain this evidence. Blood testing must be done every 2 hours whilst driving.

A person who has ***a history of established ischaemic heart disease including a heart attack, angina, or insertion of a stent*** at any time in the past, must have three yearly exercise treadmill tests or another equivalent functional test and be able to demonstrate a satisfactory standard equivalent to DVLA group 2 standard and must have had a scan to show that the cardiac ejection fraction is at least 40%.