

TAXI DRIVER MEDICAL EXAMINATION REPORT

NOTE TO APPLICANT: PLEASE NOTE THIS MEDICAL MUST BE COMPLETED BY A GP AT YOUR OWN PRACTICE, OR A REGISTERED DOCTOR WITH ACCESS TO YOUR FULL MEDICAL RECORDS (NOT SUMMARY RECORDS)

Name of applicant	
Date of birth	
Address of applicant	

NOTE TO DOCTOR: PLEASE ENSURE THAT THE MEDICAL FORM AND THE FOLLOWING STATEMENTS ARE COMPLETED IN FULL

1)	I confirm I have seen original photographic identification (e.g. DVLA photocard, passport) for the applicant	YES	NO
2)	I confirm that the applicant is registered at this medical practice, or I have had sight of their full medical records (not summary records) when completing this form	YES	NO
3)	I confirm that the information provided is a true and accurate account of the applicant's health as known to me and as set out in their full medical records	YES	NO
4)	I confirm the applicant meets the DVLA Group 2 driver medical standard in accordance with the Assessing fitness to drive: guide for medical professionals	YES	NO

<u>Surgery stamp</u>	<u>Signature of doctor</u>
	<u>Date</u>

NOTE FOR DOCTORS

PLEASE READ THESE NOTES BEFORE COMPLETING THE EXAMINATION

The [DfT Best Practice Guidance](#) is clear that all applicants for a taxi and private hire driver's licence should undergo an assessment of their medical fitness, and that this should be the Group 2 medical standard and using the D4 medical examination report form.

Guidance as to the required standard can be found at [Assessing fitness to drive – a guide for medical professionals](#)

Where appropriate, please provide as much detail as possible with relevant questions. In addition where specific medical investigations have taken place (e.g. exercise cardiac testing, echocardiography, EEG) or where relevant specialist reports (e.g. outpatient or discharge reports) are available then copies of these should accompany the medical form. Failure to do so may delay the driver's application process. If we require further information to assess the medical form provided, we may contact you directly.

The completed and signed form can be given to the applicant who will forward this to the Licensing Authority. If preferred, you can email a scanned copy of the medical to us the relevant email address as shown below.

If you have any queries, please contact us as follows:

Licensing Team, South Oxfordshire District Council or Vale of White Horse District Council

Abbey House, Abbey Close, Abingdon, OX14 3JE

Telephone: 01235 422556

Email: licensing@southoxon.gov.uk or licensing.unit@whitehorsedc.gov.uk

NOTE FOR APPLICANTS

You are responsible for paying the fee for the medical. We (the Licensing Authority) accept no liability to pay for the medical or any associated requirements.

Please check the medical is fully complete before you send it to us. Incomplete medicals will be returned as invalid.

Applicant declaration - to be completed and signed in the presence of the doctor

You will need to provide full and accurate information to the people involved with your medical (which may include doctors, specialists and opticians) so they can carry out an appropriate assessment and identify if any additional tests etc are required. We will only share information with any persons involved in your medical assessment(s) which is relevant to your fitness to drive.

Also, where the circumstances of your case appear to suggest the need for this, the relevant medical information may need to be reviewed by the relevant Head of Service at the Licensing Authority. More details can be found in our Taxi Licensing Policy, which can be found on our website.

For information about how we process your data, your rights and who to contact, see our privacy notice on the 'Useful information and documents' page under 'Taxis and private hire' on our website.

Please read the following information carefully then initial and sign to confirm the statements below:

Name		
Date of birth		Please initial
I authorise my doctor, specialist or appropriate healthcare professional to disclose information or reports about any health or medical condition that is relevant to my fitness to drive to the Licensing Authority		
I understand that the Licensing Authority may disclose information which is relevant to my medical fitness to drive to my doctor, specialist or appropriate healthcare professional		
I declare that I have checked the details I have given on the medical form 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 hackney carriage and private hire driver's licence and it can lead to prosecution and suspension or revocation of that licence		
Sign		
Date		

e Cardiac other

Is there a history or evidence of heart failure? Yes No

If no, go to section 3f, Cardiac channelopathies

If yes, please answer all questions below.

1. Please provide the NYHA class, if known.

2. Established cardiomyopathy? Yes No
If yes, please give details in section 9, page 6.

3. Has a left ventricular assist device (LVAD) or other cardiac assist device been implanted? Yes No

4. A heart or heart/lung transplant? Yes No

5. Evidence or history of pulmonary arterial hypertension? Yes No

f Cardiac channelopathies

Is there a history or evidence of the following conditions? Yes No

If no, go to section 3g, Blood pressure

1. Brugada syndrome? Yes No

2. Long QT syndrome? Yes No
If yes to either, please give details in section 9, page 6.

g Blood pressure

All questions must be answered.

If resting blood pressure is 180 mm/Hg systolic or more and/or 100mm/Hg diastolic or more, please take a further 2 readings at least 5 minutes apart and record the best of the 3 readings in the box provided.

1. Please record today's best resting blood pressure reading. /

2. Is the applicant on anti-hypertensive treatment? Yes No
If yes, please provide three previous readings with dates if available.

<input type="text"/>	/	<input type="text"/>							
<input type="text"/>	/	<input type="text"/>							
<input type="text"/>	/	<input type="text"/>							

h Cardiac investigations

Have any cardiac investigations been undertaken or planned? Yes No

If no, go to section 4, Psychiatric illness

If yes, please answer questions 1 to 5.

1. Is there a history of the following: Yes No

(a) left bundle branch block (LBBB)?

(b) right bundle branch block (RBBB)?

(c) paced rhythm?

If yes to (a), (b) or (c), please give details in section 9, page 6.

Note: If yes to questions 2 to 5, please give dates in the boxes provided, give details in section 9, page 6.

2. Has an exercise ECG been undertaken (or planned)? Yes No

3. Has an echocardiogram been undertaken (or planned)? Yes No

(a) If undertaken, is or was the left ejection fraction greater than or equal to 40%?

4. Has a coronary angiogram been undertaken (or planned)? Yes No

5. Has a myocardial perfusion scan, stress echo study or cardiac MRI been undertaken (or planned)? Yes No

4 Psychiatric illness

Is there any significant mental illness or cognitive impairment likely to affect safe driving? Yes No

If no, go to section 5, Substance misuse

If yes, please answer all questions below.

1. Significant psychiatric disorder within the past 6 months? If yes, please confirm condition. Yes No

2. Psychosis or hypomania/mania within the past 12 months, including psychotic depression? Yes No

3. (a) Dementia or cognitive impairment? Yes No
(b) Are there concerns which have resulted in ongoing investigations for such possible diagnoses?

5 Substance misuse

Is there a history of drug/alcohol misuse or dependence? Yes No

If no, go to section 6, Sleep disorders

If yes, please answer all questions below.

1. Is there a history of an alcohol use disorder (sufficient to cause significant physical, mental or social consequences) in the past 10 years? Yes No

2. If there is a history of an alcohol use disorder, has this been associated with any of the following features which indicate a physiological dependence on alcohol: Yes No

(a) Required medical assisted withdrawal?
Date treatment ended:

(b) Alcohol withdrawal seizure?
Date of last event:

3. Based on their clinical record and/or account of drinking provided to you, is their alcohol consumption: Yes No Don't know

(a) Abstinent? Yes No Don't know
If yes, for how long:

(b) Controlled? Yes No Don't know
If yes, for how long:

4. Use of illegal drugs or other substances, or misuse of prescription medication in the last 6 years? Yes No

(a) If yes, the type of substance misused?

(b) Is it controlled?

(c) Has the applicant undertaken an opiate treatment programme?
If yes, give date started

Applicant's full name

Date of birth

