

# 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 <a href="#">Assessing fitness to drive: guide for medical professionals</a>	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](mailto:licensing@southoxon.gov.uk) or [licensing.unit@whitehorsedc.gov.uk](mailto: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:**

<b>Name</b>		
<b>Date of birth</b>		<b>Please initial</b>
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		
<b>Sign</b>		
<b>Date</b>		







**1 Neurological disorders**

Please tick ✓ the appropriate boxes  
Does the applicant have a history or evidence of any neurological disorder (see conditions in questions 1 to 11 below)?  
**If no, go to section 2, Diabetes mellitus**  
If yes, please answer all questions below.

Yes No

1. Has the applicant had any form of seizure? Yes No

(a) Has the applicant had more than one seizure episode?

(b) Please give date of first and last episode.  
First episode            
Last episode

(c) Is the applicant currently on anti-seizure medication?

(d) If no longer treated, when did treatment end?

(e) Has the applicant had a brain scan?    
If yes, please give details in section 9, page 6.

Yes No

2. Has the applicant experienced any dissociative/functional seizures?

(a) If yes, please give date of most recent episode.

(b) If yes, have any of these episode(s) occurred or are they considered likely to occur whilst driving?

Yes No

3. Stroke or TIA?

If yes, give date.

(a) Has there been a full recovery?

(b) Has a carotid ultrasound been undertaken?

(c) If yes, was the carotid artery stenosis >50% in either carotid artery?

(d) Is there a history of multiple strokes/TIAs?

4. Sudden and disabling dizziness or vertigo within the last year with a liability to recur?

5. Subarachnoid haemorrhage (non-traumatic)?

6. Significant head injury within the last 10 years?

7. Any form of brain tumour?

8. Other intracranial pathology?

9. Chronic neurological disorder(s)?

10. Parkinson's disease?

11. Blackout, impaired consciousness or loss of awareness within the last 5 years?

**2 Diabetes mellitus**

Does the applicant have diabetes mellitus? Yes No

**If no, go to section 3, Cardiac**  
If yes, please answer all questions below.

1. Is the diabetes treated by: Yes No

(a) Insulin?    
If no, go to 1c  
If yes, please give date started on insulin.

(b) Are there at least 4 continuous weeks of glucose readings stored on a memory meter or meters?    
If no, please give details in section 9, page 6.

(c) Other injectable treatments?

(d) A Sulphonylurea or a Glinide?

(e) Oral hypoglycaemic agents and diet?

(f) Diet only?

2. (a) Does the applicant monitor their glucose level using continuous glucose monitoring (CGM)? Yes No

(b) If yes, is the continuous glucose monitoring (CGM) device approved for non-adjunctive use?

(c) Does the applicant carry a finger prick monitoring device?

(d) Does the applicant test glucose at least twice every day?

(e) Does the applicant test glucose at times relevant to driving? (Within 2 hours of starting their first journey of the day and continuing to check at least every 2 hours during their journey. There must be no more than 2 hours between glucose checks at any time during their journey).

(f) Does the applicant keep fast-acting carbohydrate within easy reach whilst driving?

(g) Does the applicant have a clear understanding of diabetes and the necessary precautions for safe driving?

3. (a) Has the applicant ever had a hypoglycaemic episode? Yes No

(b) Is there full awareness of hypoglycaemia?

4. Is there a history of hypoglycaemia in the last 12 months requiring the assistance of another person? Yes No

If yes, please give details and dates below.

5. Has there been laser treatment or intra-vitreous treatment for retinopathy? Yes No

If yes, please give most recent date of treatment.

Applicant's full name

Date of birth



### 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

## 6 Sleep disorders

1. Is there a history or evidence of Obstructive Sleep Apnoea Syndrome or any other medical condition causing excessive sleepiness? Yes  No

**If no, go to section 7, Other medical conditions.**  
If yes, please give diagnosis and answer all questions below.

- a) If Obstructive Sleep Apnoea Syndrome, please indicate the severity:

Mild (AHI <15)

Moderate (AHI 15 - 29)

Severe (AHI >29)

Not known

If another measurement other than AHI is used, it must be one that is recognised in clinical practice as equivalent to AHI. DVLA does not prescribe different measurements as this is a clinical issue. Please give details in section 9 page 6, Further details.

- b) Please answer questions (i) to (iv) for **all** sleep conditions.

(i) Date of diagnosis:       Yes  No

(ii) Is it controlled successfully?

(iii) Is applicant compliant with treatment?

(iv) Date of last review.

## 7 Other medical conditions

1. Is there a history or evidence of narcolepsy? Yes  No

2. Is there any impairment resulting from either a physical or non-physical medical condition which is likely to affect the ability to control a vehicle? Yes  No

If yes, please provide information in section 9, page 6.

3. Is there a history of bronchogenic carcinoma or other malignant tumour with a significant liability to metastasise cerebrally? Yes  No

4. Is there any illness that may cause significant fatigue or cachexia that affects safe driving? Yes  No

5. Does the applicant have a history of liver disease of any origin? Yes  No

If yes, is this the result of alcohol misuse?

If yes, please give details in section 9, page 6.

6. Is there a history of renal failure? Yes  No

If yes, please give details in section 9, page 6.

7. Does the applicant have severe symptomatic respiratory disease causing chronic hypoxia? Yes  No

8. Does the applicant have any other medical condition that could affect safe driving? Yes  No

If yes, please provide details in section 9, page 6.

## 8 Medication

Is the applicant currently prescribed any of the following medication: Yes  No

(a) Anti-seizure?

(b) Clozapine?

(c) Sulphonylurea or a Glinide?

(d) Insulin?

## 9 Further details

Do not send any notes not related to fitness to drive.

Use the space below to provide any additional information.

Applicant's full name

Date of birth

