Hackney Carriage Medical Form

Group II Medical Examination Report

Checked by:	Date:
Licence/application number:	

Taxi Licencing
taxis@swale.gov.uk
Licensing Team
Swale House, East Street
Sittingbourne ME10 3HT

Group II Medical Examination Report Form

Information Notes

It is a requirement under Section 57 of the Local Government (Miscellaneous Provisions) Act 1976 to provide a Medical Examination Report to the effect that you are physically fit to drive a Public, Private Hire or Contract vehicle.

This form is to be completed by the applicant's own General Practitioner (GP) or another GP within the same practice, or a GP at another practices, or any GMC registered Doctor provided they have access to the applicant's NHS records at the time of the examination.

Drivers are required to complete a Group II Medical Report Form every three years, until the age of 65, when an annual form is required.

*there are certain medical conditions that require an annual medical report.
Any fee charged is payable by the applicant.

- Please complete this form – alternative forms will not normally be accepted.
- Please complete in block capitals using black ink.

Applicants must take a form of photographic identity to the examination, eg. your passport or DVLA driving licence.

Licensing officers are not permitted to complete or amend forms on behalf of applicants for legal reasons.

Guidance notes

What you have to do:

1. In assessing an individual's medical fitness, Swale Council has decided to be guided by the DVLA Group 2 standards.
2. If, after reading the notes, you have any doubts about your ability to meet the medical or eyesight standards, consult your GP/ Optician before you arrange for this medical form to be completed, as your GP will normally charge you for completing it. In the event of your application being refused, the fee you pay your GP is not refundable. Swale Borough Council has no responsibility for the fee payable to your GP.
3. Fill in Section 8 of this report in the presence of the GP carrying out the examination.
4. A delay in submitting your Group II Medical Report Form (once required) may delay the processing of your application.
5. Provide a current passport size photo to the GP at the time of examination.

What the GP has to do:

1. Medical practitioners are asked to confirm that the applicant complies with the Group 2 medical standards, set by the Driver and Vehicle Licensing Agency (DVLA). Read the DVLA medical standards for a summary at: www.gov.uk/government/publications/assessing-fitness-to-drive-a-guide-for-medical-professionals.
2. Arrange for the patient to be seen and examined. (GPs must ensure the identity of the individual they are carrying out the examination on.)
3. Applicants who may be asymptomatic at the time of the examination should be advised that, if in future they develop symptoms of a condition that could affect safe driving and they hold either a Hackney Carriage and/or Private Hire driver licence, they must inform the Taxi Licensing Section (email: taxis@swale.gov.uk).
4. Please ensure that you have completed all sections required within this form. If this report does not bring out important clinical details with respect to driving, please give details in Section 6.
5. Sign to verify that the photo is a true reflection of the applicant who attended the medical examination.

This page must be completed by the applicant.

Your details:

To be completed in BLOCK CAPITAL LETTERS, one letter to each box only, with a space between your first/middle names and surname

Your full name (surname last):

Address:

Postcode:

Date of birth: D D / M M / Y Y Y Y

Email address:

Daytime telephone number

Your doctor's details:

Name of doctor or GP practice:

Address:

Postcode:

Email address:

Daytime telephone number:

Vision assessment – to be completed by your optician/optometrist

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. Please state the visual acuity of each eye. Snellen readings with a plus (+) or minus (–) are not acceptable.

   If 6/7.5, 6/60 standard is not met, the applicant may need further assessment by an optician.

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

3. Is the visual acuity at least 6/7.5 in the better eye and as least 6/60 in the other eye? (Corrective lenses may be worn to meet this standard.)

   Yes ☐ No ☐

4. Were corrective lenses worn to meet the standard?

   Yes ☐ No ☐

   If Yes,

   glasses ☐ contact lenses ☐ both together ☐

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 a correction is worn for driving, is it well tolerated?

   If No, please provide details in the box provided.

   Yes ☐ No ☐

7. Is there a history of any medical condition that may affect the applicant's binocular field of vision (central and/or peripheral)? If formal visual field testing is considered necessary, DVLA will commission this at a later date.

   Yes ☐ No ☐

8. Is there diplopia?

   If yes, please provide full details in box provided.

   Yes ☐ No ☐

9. When questioned, does the applicant report symptoms of intolerance to glare and/or impaired contrast to sensitivity and/or impaired twilight vision?

   Yes ☐ No ☐

10. Does the applicant have any other ophthalmic condition?

    If Yes, please give details in box provided.

    Yes ☐ No ☐

Details/additional comments	Name of examining doctor/optician (print) Signature of examining doctor/optician Date of signature: D D / M M / Y Y Y Y Please provide your GOC, HPC or GMC number. _____
	Doctor's/optometrist's/optician's stamp

Section 1. Nervous system – to be completed by your GP

1. Has the patient had any form of epileptic attack? If Yes, please answer all questions below and supply reports if available.

   Yes ☐ No ☐

   (a) Has the patient had more than one attack?

   Yes ☐ No ☐

   (b) Please give date of first and last attack:

   First attack D D / M M / Y Y Y Y Last attack D D / M M / Y Y Y Y

   (c) Is the applicant currently on anti-epileptic medication? If Yes, please give details of current medication in Section 6.

   Yes ☐ No ☐

   (d) If no longer treated, please give date when treatment ended.

   D D / M M / Y Y Y Y

   (e) Has the patient had a brain scan? If Yes, please give details in Section 6.

   Yes ☐ No ☐

   (f) Has the patient had an EEG?

   Yes ☐ No ☐

2. Is there any history of stroke or TIA? If yes, please give date.

   Yes ☐ No ☐

   Has there been a full recovery?

   Yes ☐ No ☐

   Has a carotid ultrasound taken place?

   Yes ☐ No ☐

3. Has there been sudden and disabling dizziness/vertigo within the past one year with a liability to recur?

   Yes ☐ No ☐

4. Subarachnoid haemorrhage

   Yes ☐ No ☐

5. Serious traumatic brain injury within the past ten years

   Yes ☐ No ☐

6. Any form of brain tumour

   Yes ☐ No ☐

7. Other brain surgery or abnormality

   Yes ☐ No ☐

8. Chronic neurological disorder

   Yes ☐ No ☐

9. Parkinson's disease

   Yes ☐ No ☐

10. Is there any history of blackout or impaired consciousness within the past five years? If Yes, please give dates and details in Section 6.

    Yes ☐ No ☐

Section 2. Diabetes mellitus

1. Does the patient have diabetes mellitus? If Yes, please answer all the following questions.

   Yes ☐ No ☐

   (a) Is the diabetes managed by Insulin?

   Yes ☐ No ☐ If Yes, please give date started on insulin: D D / M M / Y Y Y Y

   (b) If treated with insulin, are there at least three months of blood glucose readings stored on a memory meter? If No, please give details in Section 6.

   Yes ☐ No ☐

   (c) Are there other injectable treatments?

   Yes ☐ No ☐

   (d) Is there a Sulphonylurea or a Glinde?

   Yes ☐ No ☐

   (e) Oral hypoglycaemic agents or diet?

   Yes ☐ No ☐

   (f) Diet only?

   Yes ☐ No ☐

2. (a) Does the applicant test blood glucose at least twice every day?

   Yes ☐ No ☐

   (b) Does the applicant test at times relevant to driving?

   Yes ☐ No ☐

   (c) Does the applicant keep fast-acting carbohydrate within easy reach when driving?

   Yes ☐ No ☐

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

   Yes ☐ No ☐

3. Is there any evidence of impaired awareness of hypoglycaemia?

   Yes ☐ No ☐

4. Is there a history of hypoglycaemia in the past 12 months requiring the assistance of another person? If Yes, please give details in Section 6.

   Yes ☐ No ☐

5. (a) Is there evidence of: Loss of visual field? If Yes, please give details in Section 6.

   Yes ☐ No ☐

   (b) Severe peripheral neuropathy, sufficient to impair limb function for safe driving? If Yes, please give details in Section 6.

   Yes ☐ No ☐

6. Has there been any laser treatment or intravitreal treatment for retinopathy? If Yes, please give details in Section 6.

   Yes ☐ No ☐ If Yes, please give date(s) of treatment: D D / M M / Y Y Y Y

Section 3. Psychiatric illness

Is there a history of or evidence of psychiatric illness or drug/alcohol misuse within the past three years? If Yes, please answer all the questions. Please provide full details in Section 6, including dates, period of stability and, where appropriate, consumption and frequency of use. If No, please go to Section 4.

Yes ☐ No ☐

1. Has there been significant psychiatric disorder within the past six months?

   Yes ☐ No ☐

2. Has there been psychosis or hypomania/mania within the past 12 months, including psychotic depression?

   Yes ☐ No ☐

3. Has there been dementia or cognitive impairment?

   Yes ☐ No ☐

4. Has there been persistent alcohol misuse in the past 12 months?

   Yes ☐ No ☐

5. Has there been alcohol dependency in the past three years?

   Yes ☐ No ☐

6. Has there been persistent drug misuse in the past 12 months?

   Yes ☐ No ☐

7. Has there been drug dependency in the past three years?

   Yes ☐ No ☐

Section 4. Cardiac

Section 4A coronary artery disease

Is there a history of or evidence of coronary artery disease?

If Yes, please answer all questions below and give details at Section 6, enclosing relevant hospital notes.

If No, please go to Section 4B.

Yes ☐ No ☐

1. Has the applicant ever suffered from angina?

   Yes ☐ No ☐ If Yes, please give date: D D / M M / Y Y Y Y

2. Has there been acute coronary syndrome, including myocardial infarction?

   Yes ☐ No ☐ If Yes, please give date: D D / M M / Y Y Y Y

3. Has there been coronary angioplasty (PCI)?

   Yes ☐ No ☐ If Yes, please give date of the most recent intervention: D D / M M / Y Y Y Y

4. Has there been coronary artery bypass graft surgery?

   Yes ☐ No ☐ If Yes, please give date: D D / M M / Y Y Y Y

Section 4B Cardiac arrhythmia

Is there a history or evidence of cardiac arrhythmia

If Yes, please answer the questions below and give details in Section 6.

If No, go to Section 4C.

Yes ☐ No ☐

1. Has there been a significant disturbance of cardiac rhythm (ie. sinoatrial disease, significant atrioventricular conduction defect, atrial flutter/fibrillation, narrow or broad complex tachycardia) in the past five years?

   Yes ☐ No ☐

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

   Yes ☐ No ☐

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

   Yes ☐ No ☐

4. Has a pacemaker been implanted?

   Yes ☐ No ☐

If Yes:

(a) Please give date: D D / M M / Y Y Y Y

(b) Is the patient free of symptoms that caused the device to be fitted?

Yes ☐ No ☐

(c) Does the patient attend a pacemaker clinic regularly?

Yes ☐ No ☐

Section 4C Peripheral Arterial Disease

Is there a history or evidence of peripheral arterial disease (excluding Buerger's disease aortic aneurysm/dissection)?

If Yes, please answer the questions below and give details in Section 6 enclosing any relevant hospital notes.

If No, go to Section 4D.

Yes ☐ No ☐

1. Peripheral Arterial Disease (excluding Buerger's disease)

   Yes ☐ No ☐

2. Does the patient have claudication?

   Yes ☐ No ☐

If Yes, please say how long in minutes the patient can walk at a brisk pace before being symptom-limited:

3. Aortic aneurysm

   Yes ☐ No ☐

If Yes:

(a) Site of aneurysm (please tick)

Thoracic ☐ Abdominal ☐

(b) Has it been repaired successfully?

Yes ☐ No ☐

(c) Is the transverse diameter currently >5.5cms?

Yes ☐ No ☐

If No, please provide latest measurement:

Date obtained: D D / M M / Y Y Y Y

4. Dissection of the aorta repaired successfully?
   If Yes, please provide copies of all reports to include those dealing with any surgical treatment.

   Yes ☐ No ☐

5. Is there a history of Marfan syndrome?
   If Yes, please provide relevant hospital notes.

   Yes ☐ No ☐

Section 4D Valvular/congenital heart disease

Is there a history of or evidence of valvular/congenital heart disease?
If Yes, please answer all questions below and give details in Section 8 of the form. If No, go to Section 4E.

Yes ☐ No ☐

1. Is there a history of congenital heart disease?

   Yes ☐ No ☐

2. Is there a history of heart valve disease?

   Yes ☐ No ☐

3. Is there a history of aortic stenosis? If Yes, please provide relevant reports.

   Yes ☐ No ☐

4. Is there any history of embolism? (not pulmonary embolism)

   Yes ☐ No ☐

5. Does the patient currently have significant symptoms?

   Yes ☐ No ☐

6. Has there been any progression since the last licence application? (if relevant)

   Yes ☐ No ☐

Section 4E Cardiac other

Is there a history of or evidence of heart failure? If Yes, please answer all questions below. If No, go to Section 4F

Yes ☐ No ☐

1. Established cardiomyopathy?

   Yes ☐ No ☐

2. Has a ventricular assist device (LVAD) been implanted?

   Yes ☐ No ☐

3. A heart or heart/lung transplant?

   Yes ☐ No ☐

4. Untreated atrial myxoma

   Yes ☐ No ☐

Section 4F Cardiac Investigations

1. Have any cardiac investigations been undertaken or planned? If No, go to Section 4G.
   If Yes, please answer all questions

   Yes ☐ No ☐

   (a) Pathological Q waves?

   Yes ☐ No ☐

   (b) Left bundle branch block?

   Yes ☐ No ☐

   (c) Right bundle branch block?

   Yes ☐ No ☐

2. Has the exercise ECG been undertaken (or planned)?

   Yes ☐ No ☐ If Yes, please give date and give details in Section 6. D D / M M / Y Y Y Y

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

   Yes ☐ No ☐

   (a) If Yes, please give date and give details in Section 6. D D / M M / Y Y Y Y

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

   Yes ☐ No ☐

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

   Yes ☐ No ☐ If Yes, please provide date and give details in Section 8. D D / M M / Y Y Y Y

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

   Yes ☐ No ☐ If Yes, please provide date and give details in Section 8. D D / M M / Y Y Y Y

6. Has a Myocardial Perfusion Scan or Stress Echo study been undertaken (or planned)?

   Yes ☐ No ☐ If Yes, please provide date and give details in Section 8. D D / M M / Y Y Y Y

Section 4G Blood pressure
This section must be filled in for all patients

If the blood pressure is 180/100mmHg systolic or more and/or 100mmHg diastolic or more, please take a further two readings at least five minutes apart and record the best of the three readings in the box provided.

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

2. Is the patient on antihypertensive treatment?

   Yes ☐ No ☐

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

1. Blood pressure reading: ☐ Date: D D / M M / Y Y Y Y

2. Blood pressure reading: ☐ Date: D D / M M / Y Y Y Y

3. Blood pressure reading: ☐ Date: D D / M M / Y Y Y Y

Section 5. General

All questions must be answered. If your answer is Yes to any question, please give full details in Section 6.

1. Is there currently any functional impairment that is likely to affect control of the vehicle?
   Yes ☐ No ☐

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

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

4. Is the patient profoundly deaf?
   Yes ☐ No ☐

   If Yes, is the patient able to communicate in the event of an emergency by speech or by using a device, eg. a textphone?
   Yes ☐ No ☐

5. Is there a history of liver disease of any origin? If Yes, please give details in Section 6.
   Yes ☐ No ☐

6. Is there a history of renal failure? If Yes, please give details in Section 6.
   Yes ☐ No ☐

7. Is there a history of or evidence of Obstructive sleep apnoea syndrome or any other medical condition causing excessive sleepiness?
   Yes ☐ No ☐ If Yes, please give diagnosis.

   (a) If Obstructive sleep apnoea syndrome, please indicate severity:
   Mild (AHI 15) ☐ Moderate (AHI 15–29) ☐ Severe (AHI >29) ☐ Unknown ☐

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

   (b) Please answer questions i–vi for all sleep conditions.

   i Date of diagnosis: D D / M M / Y Y Y Y
   ii Is it controlled successfully? Yes ☐ No ☐
   iii If Yes, please state treatment:
   iv Is the applicant compliant with treatment? Yes ☐ No ☐
   v Please state period of control:
   vi Date of last review: D D / M M / Y Y Y Y

8. Does the applicant have severe symptomatic respiratory diseasecausing chronic hypoxia?
   Yes ☐ No ☐

9. Does any medication currently taken cause the applicant side effects that could affect safe driving? If Yes, please provide details of medication and symptoms in Section 6.
   Yes ☐ No ☐

10. Does the applicant have an ophthalmic condition? If Yes, please provide details in Section 6.
    Yes ☐ No ☐

11. Does the patient have any other medical condition that could affect safe driving? If Yes, please provide details in Section 6.
    Yes ☐ No ☐

12. Do you consider the applicant unable to load/unload a wheelchair bound passenger without assistance?

Yes ☐ No ☐

13. Does the applicant have any allergies to dogs?

Yes ☐ No ☐

Section 6 Further Details

Please provide section/question numbers the notes refer to – use additional sheets if required and attach only documents that relate to fitness to drive.

Section 7. Consultant details	
Consultant in:	Consultant in:
Name:	Name:
Address:	Address:
Date of last appointment: D D / M M / Y Y Y Y	Date of last appointment: D D / M M / Y Y Y Y
Consultant in:	Consultant in:
Name:	Name:
Address:	Address:
Date of last appointment: D D / M M / Y Y Y Y	Date of last appointment: D D / M M / Y Y Y Y

Section 8. Medication Details of all current medication (continue on separate sheet if necessary).	
Medication:	Medication:
Dosage:	Dosage:
Reason for taking:	Reason for taking:
Medication:	Medication:
Dosage:	Dosage:
Reason for taking:	Reason for taking:
Medication:	Medication:
Dosage:	Dosage:
Reason for taking:	Reason for taking:

Section 9. Additional information	
Applicant’s weight (kg)	Applicant’s weight (kg)
Height (cms)	Height (cms)

Section 10. Examining doctor's details

To be completed by the doctor carrying out the examination.
Please ensure that all sections of the form (including the declaration) have been completed. Failure to do so will result in the form being sent back to you.

Name:	
Address:	
Telephone:	Fax:
email:	

Applicant – consent and declaration

This section must be completed by the applicant and must not be altered in any way.

Important information about consent

Swale Borough Council may in certain circumstances, as part of its assessment of your fitness to drive a hackney carriage or private hire vehicle, require additional information about your medical fitness.

I declare that I have checked the details I have given on the enclosed medical report 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 or private hire driver licence.

I authorise my doctor(s) and specialist(s) to release reports to Swale Borough Council Licensing Section about my medical condition if necessary*. I declare that I have checked the details I have given on the enclosed questionnaire and that to the best of my knowledge they are correct.

I authorise Swale Borough Council Licensing Section 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 your fitness to drive.)

Signature:	Date: D D / M M / Y Y Y Y

Note about consent

*The Council will only ask for release of medical reports if required, ie. where an application needs to be determined at a hearing on medical grounds.

The Council will never under any circumstances release information that is not relevant to fitness to drive, nor would we expect to receive this from your doctor(s).

We hope you will find this helpful and reassuring and will return the signed consent.

General Practitioner declaration

I certify that I am the named applicant's General Practitioner or a General Practitioner with access to the applicant's NHS records at the time of the examination.

I certify that I have reviewed all the applicant's medical history and have today examined the named applicant's ability to act as a licensed driver in the Borough of Swale.

I declare that the answers to all questions are true to the best of my knowledge and belief.

I understand that it is an offence for the person completing this form to make a false statement or omit relevant details.

Please tick as appropriate:

- ☐ I consider the applicant fit to operate a licensed vehicle.
- ☐ I consider the applicant unfit to operate a licensed vehicle.

Name:

Signature:	Date: D D / M M / Y Y Y Y

GP's practice stamp: