

# Medical Report on an Applicant for a Hackney Carriage/Private Hire Vehicle Driver's Licence

## Fitness to Drive a Class 2 Vehicle

Notes:

- For the Applicant (Part A)**  
This medical report cannot be issued free of charge as part of the National Health Service. The applicant must pay the Medical Practitioner's fee, unless other arrangements have been made. The Licensing Authority accepts no liability to pay.
- This report should be completed by a General Practitioner with whom you have been registered for at least **12 months** or by a General Practitioner who has access to your medical records and who may require a supplementary report.
- For the Medical Practitioner (part B)**
  - When completing the medical report, please have regard to the "**At a Glance Guide to the Current Medical Standards of Fitness to Drive**" issued by Drivers Medical Unit, DVLA, Swansea, for doctors conducting these examinations.
  - Please tick the answers that apply. Use the right hand margin if you want add anything or write 'see note attached' and use a separate sheet of paper.

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### **PART A INFORMATION ABOUT THE APPLICANT (See note 1)**

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- Full Name (BLOCK CAPITALS)  
.....
- Address .....  
.....  
..... Post Code .....
- Date of Birth ..... (Day) .....(Month) .....(Year)
- Name and address of your present practitioner or of the group practice with which you have been registered for the last twelve months  
Address .....  
.....  
..... Post Code .....
- I hereby consent to the Medical Adviser to the Licensing Authority receiving reports from my doctors and specialists about my medical condition.

Applicant's Signature ..... Date

**(Please sign in the presence of the Medical Practitioner who signs the report (Part B)  
When complete please return to:-**

Runnymede Borough Council  
Technical Services Department  
Civic Offices  
Station Road  
Addlestone

Surrey KT15 2AH

Tel: 01932 838383

Fax: 01932 425703

**PART B MEDICAL REPORT - to be completed by the Doctor**

Section 1 Cardiac	Please give details	
<p>NOTE: This report must not be completed in respect of applicants who have had coronary artery by-pass surgery within the last 6 months or angioplasty within the last 3 months. The report should only be completed after these specified periods have elapsed.</p>		
	<b>Yes</b>	<b>No</b>
<b>a</b> Is there evidence of congenital heart disease requiring Consultant Cardiological review?	<input type="checkbox"/>	<input type="checkbox"/>
<b>b</b> Is a cardiac pacemaker fitted?	<input type="checkbox"/>	<input type="checkbox"/>
<b>c</b> Is there a history of		
<b>i</b> A single cardiac infarction?	<input type="checkbox"/>	<input type="checkbox"/>
<b>ii</b> Successful coronary artery by-pass graft (CAGB) surgery more than 6 months ago?	<input type="checkbox"/>	<input type="checkbox"/>
<b>iii</b> Successful coronary angioplasty more than 3 months ago?	<input type="checkbox"/>	<input type="checkbox"/>
<p>NOTE: a resting ECG is required with this report only if any questions in section 1c are answered in the affirmative.</p>		
<b>d</b> In respect of the NOTE above, does a resting ECG show typical Q waves of infarction? NOTE: a relevant Q wave is defined as having an amplitude of 40 milliseconds and a depth of at least a 1/3 rd of the succeeding R wave in any lead apart from AVR and V1.	<input type="checkbox"/>	<input type="checkbox"/>
	<b>Yes</b>	<b>No</b>
<b>e</b> Is there evidence of left bundle branch block?	<input type="checkbox"/>	<input type="checkbox"/>
<b>f</b> Does the applicant suffer from angina or require continuing symptomatic treatment for angina?	<input type="checkbox"/>	<input type="checkbox"/>
<b>g</b> Is there a history of more than one cardiac infarction or coronary heart attack?	<input type="checkbox"/>	<input type="checkbox"/>
<b>h</b> Is there persisting atrial fibrillation or a history of two episodes of cardiac arrhythmia in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
<b>i</b> Is there a history of cardio-vascular aneurysm?	<input type="checkbox"/>	<input type="checkbox"/>
<b>j</b> Has the applicant had a heart transplant?	<input type="checkbox"/>	<input type="checkbox"/>
<b>k</b> Is there a history of peripheral arterial disease leading to sick absence from work, or associated with cardiac infarction?	<input type="checkbox"/>	<input type="checkbox"/>
<b>l</b> Is the established systolic blood pressure 200 or over, or is the established diastolic blood pressure 110 or over?	<input type="checkbox"/>	<input type="checkbox"/>
<b>m</b> Is the established systolic blood pressure 170 or over, or is the established diastolic blood pressure 95 or over?	<input type="checkbox"/>	<input type="checkbox"/>
<b>n</b> Is hypotensive medication prescribed? If "Yes" does it give rise to giddiness or fainting?	<input type="checkbox"/>	<input type="checkbox"/>
<b>o</b> Is there a history of heart valve surgery or heart disease requiring anti-coagulant medication?	<input type="checkbox"/>	<input type="checkbox"/>
<b>p</b> Is there a history of X-ray evidence of heart enlargement? If "Yes" is the cardiothoracic ratio 0.55 or over?	<input type="checkbox"/>	<input type="checkbox"/>
	<b>Yes</b>	<b>No</b>
<b>Section 2 Diabetes Mellitus</b>		
<b>a</b> Is the applicant a diabetic? If "Yes" answer <b>b</b> and <b>c</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>b</b> Is insulin treatment required?	<input type="checkbox"/>	<input type="checkbox"/>
<b>c</b> Is there evidence of diabetic retinopathy laser treatment, or severe peripheral neuropathy?	<input type="checkbox"/>	<input type="checkbox"/>

**Section 3 Nervous System**

	<b>Yes</b>	<b>No</b>
<b>a</b> Has the applicant suffered an epileptic attack since attaining the age of 5 years?	<input type="checkbox"/>	<input type="checkbox"/>
<b>b</b> Is there a history of blackout(s) or recurring episodes of altered consciousness other than simple syncope?	<input type="checkbox"/>	<input type="checkbox"/>
<b>c</b> Is there a history of transient ischaemia, amaurosis fugax or stroke?	<input type="checkbox"/>	<input type="checkbox"/>
<b>d</b> Is there a history of recurring Ménière's disease or vertebro-basilar artery insufficiency in the past 2 years?	<input type="checkbox"/>	<input type="checkbox"/>
<b>e</b> Is there a history of Multiple Sclerosis or Parkinsonism?	<input type="checkbox"/>	<input type="checkbox"/>
<b>f</b> Is there a history of major brain surgery (other than to the posterior fossa)?	<input type="checkbox"/>	<input type="checkbox"/>
<b>g</b> Is there a history of head injury with evidence of an intra-cerebral haematoma, early epilepsy or compound depressed skull fracture?	<input type="checkbox"/>	<input type="checkbox"/>
<b>h</b> Is there profound deafness that prevents communication by telephone?	<input type="checkbox"/>	<input type="checkbox"/>

**Section 4 Psychiatric Illness**

	<b>Yes</b>	<b>No</b>
<b>a</b> Has the applicant suffered a psychotic illness or required treatment for a psychotic illness in the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>
<b>b</b> Has the applicant suffered from a mental disorder requiring treatment with psychotropic medication within the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>
<b>c</b> Is there a history of dementia?	<input type="checkbox"/>	<input type="checkbox"/>
<b>d</b> Is there any history of alcohol abuse in the last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>
<b>e</b> Is there any history of drug or substance abuse in the last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>

**Section 5 Vision**

NOTE: Visual acuities must be measured by Snellen chart  
If in doubt, please refer to local optician for assessment.

	<b>Yes</b>	<b>No</b>	
<b>a</b> Is the visual acuity with or without the use of corrective lenses worse than 6/9 in one eye and 6/12 in the other eye?	<input type="checkbox"/>	<input type="checkbox"/>	
i. If "Yes", please state the acuities without lenses    ii. Acuities corrected by lenses			
Left: <input type="text"/>	Right: <input type="text"/>	Left: <input type="text"/>	Right: <input type="text"/>
<b>b</b> Is the uncorrected visual acuity (ie without the use of spectacles or contact lenses) worse than 3/60 in either eye - equivalent to reading 6/60 line at 3 metres?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>c</b> Is the applicant without sight in one eye?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>d</b> Is there diplopia or evidence of a pathological field defect - eg hemianopia?	<input type="checkbox"/>	<input type="checkbox"/>	

**Section 6 Malignant Growths**

	<b>Yes</b>	<b>No</b>
<b>a</b> Is there a history of bronchogenic carcinoma, malignant melanoma, breast cancer or hypernephroma in the last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>
<b>b</b> Is there a history of malignant brain lesion?	<input type="checkbox"/>	<input type="checkbox"/>

