









## 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 and enclose relevant hospital notes.

1. Please provide the NYHA class, if known.

2. Established cardiomyopathy? Yes No  
If Yes, please give details in section 9, page 7.

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. Untreated atrial myxoma? 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 7 and enclose relevant hospital notes.

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

3. Is there a history of malignant hypertension? Yes No  
If Yes, please give details in section 9, page 7 (including date of diagnosis and any treatment etc).

## 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 7.

1. Is there a history of the following: Yes No  
(a) left bundle branch block (LBBB)?    
(b) right bundle branch block (RBBB)?

If yes to (a) or (b), please provide relevant report(s) or comment in section 9, page 7.

**Note: If Yes to questions 2 to 6, please give dates in the boxes provided, give details in section 9, page 7 and provide relevant reports.**

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 24 hour ECG tape been undertaken (or planned)? Yes No

6. Has a loop recorder been implanted (or planned)? Yes No

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

## 4 Psychiatric illness

Is there a history or evidence of psychiatric illness within the last 3 years? 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 alcohol dependence in the past 6 years? Yes No

(a) Is it controlled?

(b) Has the applicant undergone an alcohol detoxification programme?

If Yes, give date started:

2. Persistent alcohol misuse in the past 3 years? Yes No

(a) Is it controlled?

3. 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 7, Further details.

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

(i) Date of diagnosis:       Yes  No

(ii) Is it controlled successfully?  Yes  No

(iii) If Yes, please state treatment.

(iv) Is applicant compliant with treatment?  Yes  No

(v) Please state period of control:

years  months

(vi) Date of last review.

## 7 Other medical conditions

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

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

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. Is the applicant profoundly deaf? Yes  No

If Yes, is the applicant able to communicate in the event of an emergency by speech or by using a device, e.g. a textphone? Yes  No

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

If Yes, is this the result of alcohol misuse?  Yes  No

If Yes, please give details in section 9, page 7.

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

If Yes, please give details in section 9, page 7.

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

9. Does any medication currently taken cause the applicant side effects that could affect safe driving? Yes  No

If Yes, please fill in section 8, Medication and give symptoms in section 9, page 7.

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

If Yes, please provide details in section 9, page 7.

## 8 Medication

Please provide details of all current medication including eye drops (continue on a separate sheet if necessary).

Medication	Dosage
Reason for taking:	
Approximate date started (if known): <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	

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Reason for taking:	
Approximate date started (if known): <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	

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Applicant's full name

Date of birth



## The applicant must fill in this page

### Applicant's declaration

You **must** fill in this section and **must not** alter it in any way.

Please read the following important information carefully then sign to confirm the statements below.

#### Important information about fitness to drive

As part of the investigation into your fitness to drive, we may require you to have a medical examination or some form of practical assessment. If we do, the people involved will need your medical details to carry out an appropriate assessment. These may include doctors, orthoptists at eye clinics or paramedical staff at a driving assessment centre. We will only release information relevant to the medical assessment of your fitness to drive. Also, where the circumstances of your case appear exceptional, the relevant medical information would need to be considered by one or more members of the Secretary of State's Honorary Medical Advisory Panels. Panel members must adhere strictly to the principle of confidentiality.

#### Declaration

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The Council may be statutorily required to supply any information you provide, to other bodies exercising functions of a public nature or the prevention and detection of fraud. For further information see <http://runymede.gov.uk/datamatching>.

**Data Protection and Privacy** Any data supplied by you on this form will be processed in accordance with the General Data Protection Regulations, in supplying it you consent to the Council process is supplied. All personal information provided will be treated in the strictest confidence and will only be used by the Council or disclosed to others for a purpose permitted by law. Data is deleted in accordance with our data retention policy. We are committed to protecting your privacy when you use our services, the privacy policy explains how we use information about you and how we protect your privacy, this is published on our web site [www.runnymede.gov.uk](http://www.runnymede.gov.uk)

Name

Signature

Date

**I authorise Runnymede Borough Council to correspond with medical professionals via electronic channels (fax and/or email)**

Yes  No

#### Checklist

- Have you signed and dated the declaration? Yes
- Have you checked that the optician, optometrist or doctor has filled in all parts of the report and all relevant hospital notes have been enclosed? Yes

**When complete please return to the Taxi Licensing Officer at Runnymede Borough Council.**

#### Important

**This report is valid for 3 months from the date the doctor, optician or optometrist signs it.**