

Medical examination report

for a Group 2 (Hackney carriage/private hire driver licence)



For advice on how to fill in this form, read the leaflet INF4D available at www.gov.uk/reapply-driving-licence-medical-condition Please use black ink when you fill in this report.

Applicants: you must fill in all grey sections of this report. This includes the section below, your full name and date of birth at the end of each page and the declaration on page 8.

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Medical professionals must fill in all green sections on this report.

Important information for doctors carrying out examinations. Before you fill in this report, you must check the applicant's identity and decide if you are able to fill in the Vision on assessment on page 2. If you are unable to do this, you must inform the applicant that they will need to								
ask an optician or optometrist to fill in the Vision assessment. Examining medical professional								
Name:								
Has a company employed you or booked you to								
carry out this examination? Yes □ No □								
If Yes, you must give the company's details below.								
If 'No', you must give your practice address details								
below. (Refer to section C of INF4D.) Company or practice address								
Company or practice address								
Postcode:								
Company or practice contact number								
GMC number								
I can confirm that I have checked the applicant's								
documents to prove their identity.								
Signature of examining doctor								
Applicant's weight (kg) Applicant's height (cm)								
Number of units of Alcohol consumed each week								
Does the applicant smoke?								
Do you have access to the								
applicant's full medical record? □								



Medical examination report

Vision assessment



D4

1.	Please confirm () the scale you are using to express the applicant's visual acuities. Shellen Shellen expressed as a decimal LogMAR	5. Does the applicant report symptoms of any of the following that impairs their ability to drive? Yes No
2.	The visual acuity standard for Group 2 driving is at least 6/7.5 in one eye and at least 6/60 in the other. (a) Please provide uncorrected visual acuities for 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. R L Yes No (b) Are corrective lenses worn for driving?	Please indicate below and give full details in Q7 below. (a) Intolerance to glare (causing incapacity rather than discomfort) and/or (b) Impaired contrast sensitivity and/or (c) Impaired twilight vision 6. Does the applicant have any other ophthalmic condition affecting their visual acuity or visual field? If Yes, please give full details in Q7 below.
	If No, go to Q3. If Yes, please provide the visual acuities using the correction worn for driving. 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. R (c) What kind of corrective lenses are worn to meet this standard? Glasses Contact lenses Both together (d) If glasses are worn for driving, is the corrective power greater than plus (+)8	7. Details or additional information Name of examining doctor, optician or optometrist undertaking vision assessment
	dioptres in any meridian of either lens? (e) If correction is worn for driving, is it well tolerated? If No, please give full details in Q7.	I confirm that this report was filled in by me at examination and the applicant's history has been
3.	Is there a history of any medical condition that may affect the applicant's binocular field of vision (central and/or peripheral)? If Yes, please give full details below. If formal visual field testing is considered necessary, DVLA will commission this at a later date.	taken into consideration. Signature of examining doctor, optician or optometrist Date of signature Please provide your GOC or GMC number Doctor, optometrist or optician's stamp
4.	Is there diplopia? (a) Is it controlled? Please indicate below and give full details in Q7. Patch or Glasses Other glasses with frosted glass prism (if other please provide details)	Doctor, optometrist of opticians stamp
Ар	plicant's full name Please do not o	Date of birth DOMMYY detach this page



Medical examination report

Medical assessment

Must be filled in by a doctor

1	Neurological disorders	2	Diabetes mellitus		
Is the disor If No If Ye	se tick \(\stacktriangle \) the appropriate boxes ere a history or evidence of any neurological rder (see conditions in questions 1 to 11 below)? o, go to section 2, Diabetes mellitus s, please answer all questions below and enclose relevant oital notes.	If N	es the applicant have diabetes mellitus? o, go to section 3, Cardiac es, please answer all questions below. Is the diabetes managed by: (a) Insulin?	Yes	No No
1.	Has the applicant had any form of seizure? (a) Has the applicant had more than one seizure episode? (b) If Yes, please give date of first and last episode. First episode Last episode Last episode Last episode (c) Is the applicant currently on anti-epileptic medication? If Yes, please fill in the medication section 8, page 6. (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 7. (f) Has the applicant had an EEG? If you have answered Yes to any of above, you must supply medical reports.	2.	If No, go to 1c If Yes, please give date started on insulin. (b) Are there at least 6 continuous weeks of blood glucose readings stored on a memory meter or meters? If No, please give details in section 9, page (c) Other injectable treatments? (d) A Sulphonylurea or a Glinide? (e) Oral hypoglycaemic agents and diet? If Yes to any of (a) to (e), please fill in the medication section 8, page 6. (f) Diet only? (a) Does the applicant test blood glucose at least twice every day? (b) Does the applicant test at times relevant to driving (no more than 2 hours before the start of the first journey and every		No D
2.	Has the applicant experienced dissociative/'non-epileptic' 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?		 2 hours while driving)? (c) Does the applicant keep fast-acting carbohydrate within easy reach when driving? (d) Does the applicant have a clear understanding of diabetes and the necessary precautions for safe driving? 		
3.	Stroke or TIA? If Yes, give date. (a) Has there been a full recovery?	3.	(a) Has the applicant ever had a hypoglyaemic episode?(b) If Yes, is there full awareness of hypoglycaemia?	Yes	No
4.	(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? Sudden and disabling dizziness or vertigo within the last year with a liability to recur?	4.	Is there a history of hypoglycaemia in the last 12 months requiring the assistance of another person? If Yes, please give details and dates below.	Yes	No
5.	Subarachnoid haemorrhage (non-traumatic)?			.,	
6.	Significant head injury within the last 10 years?	5.	Is there evidence of: (a) Loss of visual field? (b) Severe peripheral neuropathy, sufficient	Yes	NO
7.	Any form of brain tumour?		to impair limb function for safe driving?		
8.	Other intracranial pathology?		If Yes, please give details in section 9, page 7.		
9.	Chronic neurological disorder(s)?	6.	Has there been laser treatment or	Yes	No
10.	Parkinson's disease?		intra-vitreal treatment for retinopathy? If Yes, please give		
11.	Blackout, impaired consciousness or loss of awareness within the last 10 years?		most recent date of treatment.		
Apı	plicant's full name		Date of birth D M M	Y	Y

3 Cardiac			 Peripheral arterial disease (excluding Buerger's disease) 		
a Coronary artery disease			aortic aneurysm/dissection		
Is there a history or evidence of coronary artery disease? If No, go to section 3b, Cardiac arrhythmia If Yes, please answer all questions below and enclose relevant hospital notes.	Yes	a a lf	there a history or evidence of peripheral rerial disease (excluding Buerger's disease), ortic aneurysm or dissection? No, go to section 3d, Valvular/congenital hear Yes, please answer all questions below and inclose relevant hospital notes.	Yes T dise	No
Has the applicant ever had an episode of angina? If Yes, please give the date of the last known attack.	Yes	No 1	Peripheral arterial disease? (excluding Buerger's disease)	Yes	No
Acute coronary syndrome including myocardial infarction? If Yes, please give date.	Yes	No 2	Does the applicant have claudication? If Yes, would the applicant be able to undertake 9	Yes	No
3. Coronary angioplasty (PCI)? If Yes, please give date of most recent intervention.	Yes	No 3	minutes of the standard Bruce Protocol ETT? Aortic aneurysm? If Yes:	Yes	No
 4. Coronary artery bypass graft surgery? If Yes, please give date. 5. If Yes to any of the above, are there any physical health problems or disabilities 	Yes	No No	 (a) Site of aneurysm: Thoracic Abdominal (b) Has it been repaired successfully? (c) Please provide latest transverse aortic diameter measurement and date obtained using measurement and date boxes. 		
(e.g. mobility, arthritis or COPD) that would make the applicant unable to undertake 9 minutes of t standard Bruce Protocol ETT? Please give detail	the	w. 4	Dissection of the aorta repaired successfully? If Yes, please provide copies of all reports including those dealing with any surgical treatments.	Yes nent.	No
b Cardiac arrhythmia		5	Is there a history of Marfan's disease? If Yes, please provide relevant hospital notes.	Yes	No
Is there a history or evidence of cardiac arrhythmia? If No, go to section 3c, Peripheral arterial diseas If Yes, please answer all questions below and encl relevant hospital notes.		Is V	there a history or evidence of alvular or congenital heart disease? No, go to section 3e, Cardiac other	Yes	No
1. Has there been a significant disturbance of cardiac rhythm? (e.g. sinoatrial disease, significant atrio-ventricular conduction defect, atrial flutter or fibrillation, narrow or broad complex tachycardia) in the last 5 years?	Yes	No If	Yes, answer all questions below and provide elevant hospital notes. Is there a history of congenital heart disease?	Yes	No
2. Has the arrhythmia been controlled satisfactorily for at least 3 months?	Yes	No	. Is there a history of heart valve disease?	Yes	No
3. Has an ICD (Implanted Cardiac Defibrillator) or biventricular pacemaker with defibrillator/cardiac resynchronisation therapy defibrillator (CRT-D type) been implanted?	Yes	No	Is there a history of aortic stenosis? If Yes, please provide relevant reports (including echocardiogram).	Yes	No
4. Has a pacemaker or a biventricular pacemaker/ cardiac resynchronisation therapy pacemaker (CRT-P type) been implanted? If Yes:	Yes	No 4	Is there history of embolic stroke? Does the applicant currently have	Yes Yes	No No
(a) Please give date of implantation.(b) Is the applicant free of the symptoms that caused the device to be fitted?(c) Does the applicant attend a pacemaker clinic regularly?			significant symptoms? Has there been any progression (either clinically or on scans etc) since the last licence application?	Yes	No
Applicant's full name	П	П			

e Cardiac other			: If Yes to questions 2 to 6, please give dates in the bo ded, give details in section 9, page 7 and provide rele		eport
Is there a history or evidence of heart failure? If No, go to section 3f, Cardiac channelopathies If Yes, please answer all questions and enclose	Yes N		Has an exercise ECG been undertaken (or planned)?	Yes	
relevant hospital notes. 1. Please provide the NYHA class, if known.		3.	Has an echocardiogram been undertaken (or planned)?	Yes	No
2. Established cardiomyopathy? If Yes, please give details in section 9, page 7.	Yes N		(a) If undertaken, is or was the left ejection fraction greater than or equal to 40%?		
3. Has a left ventricular assist device (LVAD) or other cardiac assist device been implanted?	Yes N	4. No	Has a coronary angiogram been undertaken (or planned)?	Yes	No
4. A heart or heart/lung transplant?	Yes N		Has a 24 hour ECG tape been undertaken (or planned)?	Yes	No
5. Untreated atrial myxoma?	Yes N		Has a loop recorder been implanted (or planned)?	Yes	No
f Cardiac channelopathies			DDMMYY	Ш	Ш
Is there a history or evidence of the following conditions? If No, go to section 3g, Blood pressure			Has a myocardial perfusion scan, stress echo study or cardiac MRI been undertaken (or planned)?	Yes	No
1. Brugada syndrome?	Yes N	No 4	Psychiatric illness		
Long QT syndrome?If Yes to either, please give details in section 9, page 7 and enclose relevant hospital notes.	Yes N	illne	here a history or evidence of psychiatric ess within the last 3 years? lo, go to section 5, Substance misuse ess, please answer all questions below.	Yes	No
g Blood pressure			Significant psychiatric disorder within the past 6 months? If Yes, please confirm condition.	Yes	No
All questions must be answered. If resting blood pressure is 180 mm/Hg systolic or and/or 100mm/Hg diastolic or more, please take a 2 readings at least 5 minutes apart and record the of the 3 readings in the box provided.	a further	2.	Psychosis or hypomania/mania within the past 12 months, including psychotic depression?	Yes	No
Please record today's best resting blood pressure reading. /			 (a) Dementia or cognitive impairment? (b) Are there concerns which have resulted in ongoing investigations for such 	Yes	No
Is the applicant on anti-hypertensive treatment? If Yes, please provide three previous readings with dates if available.	Yes N	5	possible diagnoses? Substance misuse		
/ DDMM	ΥY	ls t	here a history of drug/alcohol misuse dependence?	Yes	No
/ DDMM	YY		lo, go to section 6, Sleep disorders es, please answer all questions below.		
/ DDMM	Yes N		Is there a history of alcohol dependence in the past 6 years?	Yes	No
3. Is there a history of malignant hypertension? If Yes, please give details in section 9, page 7 (including date of diagnosis and any treatment etc.)			(a) Is it controlled? (b) Has the applicant undergone an alcohol detoxification programme?		H
h Cardiac investigations			If Yes, give date started:	l Y	M
Have any cardiac investigations been undertaken or planned?	Yes N	2.	Persistent alcohol misuse in the past 3 years? (a) Is it controlled?	Yes	No
If No, go to section 4, Psychiatric illness If Yes, please answer questions 1 to 7.		3.	Use of illegal drugs or other substances, or misuse of prescription medication in the last 6 years?	Yes	No
1. Is there a history of the following:(a) left bundle branch block (LBBB)?(b) right bundle branch block (RBBB)?	Yes N	No	(a) If Yes, the type of substance misused? (b) Is it controlled?		
If yes to (a) or (b), please provide relevant report(s) or comment in section 9, page 7.			(c) Has the applicant undertaken an opiate treatment programme? If Yes, give date started	ΙΥ	Y
Applicant's full name			Date of birth	I Y	

6	Sleep disorders		6. Does the applicant have a history of liver disease of any origin?	O
1.	Is there a history or evidence of Obstructive Sleep Apnoea Syndrome or any other medical condition causing excessive sleepiness? If No, go to section 7, Other medical conditi		If Yes, is this the result of alcohol misuse? If Yes, please give details in section 9, page 7.]
	If Yes, please give diagnosis and answer all qu below.		7. Is there a history of renal failure? If Yes, please give details in section 9, page 7.)
	a) If Obstructive Sleep Apnoea Syndrome, ple indicate the severity:	ase	8. Does the applicant have severe symptomatic Yes respiratory disease causing chronic hypoxia?	0
	Mild (AHI <15) Moderate (AHI 15 - 29) Severe (AHI >29) Not known If another measurement other than AHI is u	sed, it	9. Does any medication currently taken cause the applicant side effects that could affect safe driving? If Yes, please fill in section 8, Medication and give symptoms in section 9, page 7.]
	must be one that is recognised in clinical p as equivalent to AHI. DVLA does not presci different measurements as this is a clinical Please give details in section 9 page 7, Furthe	ribe issue.	10. Does the applicant have any other medical Yes No condition that could affect safe driving? If Yes, please provide details in section 9, page 7.)
	b) Please answer questions (i) to (vi) for all sle conditions.	ер	8 Medication	
	(ii) Is it controlled successfully?	Yes No	Please provide details of all current medication including eye drops (continue on a separate sheet if necessary).	
	(iii) If Yes, please state treatment.		Medication Dosage	
		Yes No	Reason for taking:	
	(iv) Is applicant compliant with treatment?(v) Please state period of control:		Approximate date started (if known):	
	years months (vi) Date of last review.		Medication Dosage Reason for taking:	
7	Other medical conditions		Approximate date started (if known):	1
		Yes No		1
1.	Is there a history or evidence of narcolepsy?		Medication Dosage	
2.	Is there currently any functional impairment that is likely to affect control of the vehicle?	Yes No	Reason for taking: Approximate date started (if known):	-
3.	Is there a history of bronchogenic carcinoma or other malignant tumour with a significant liability to metastasise cerebrally?	Yes No	Medication Dosage	
4.	Is there any illness that may cause significant fatigue or cachexia that affects safe driving?	Yes No	Reason for taking: Approximate date started (if known):	
5.	If Yes, is the applicant able to communicate in the event of an emergency by speech	Yes No Yes No	Medication Dosage	
	or by using a device, e.g. a textphone?		Reason for taking: Approximate date started (if known):	
Apı	olicant's full name		Date of birth	7

9 Further details	10 Consultants' details
Please send us copies of relevant hospital notes. Do not send any notes not related to fitness to drive. Use the	Please provide details of type of specialists or consultants, including address.
space below to provide any additional information.	Consultant in
	Reason for attendance
	Name
	Address
	Date of last appointment:
	Consultant in
	Reason for attendance
	Name
	Address
	Date of last appointment:
	If more consultants seen give details on a separate sheet.
	11 Examining doctor's signature and stamp To be filled in by the doctor carrying out the examination. Please make sure all sections of the form have been filled in. The form will be returned to you if you do not do this. I confirm that this report was filled in by me at examination and I have taken the applicant's history into account. I also confirm that I am currently GMC registered and licensed
	to practise in the UK or I am a doctor who is medically registered within the EU, if the report was filled in outside the UK. FIT / UNFIT (delete as appropriate) to drive with Group 2 entitlement. Signature of examining doctor
	Date of signature
	Doctor's stamp
	-
Applicant's full name	Date of birth D D M M Y Y

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

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.

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

Name	
Signature	
Date	
I authorise Runnymede Borough Counc to correspond with medical profession via electronic channels (fax and/or ema	als
Yes No	
Checklist	.,
 Have you signed and dated the declaration? 	Ye
 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? When complete please return to the Taxi Licensing Officer at Runnymede Borough Council. 	Ye
The state of the country and the state of th	
Important This report is valid for 3 months from the date the doctor, optician or optometrist signs it.	