Walsall Council

Medical Examination Report
Vision Assessment

To be filled in by a doctor or optician/optometrist

Doctors – You MUST read the notes in the Guidance leaflet attached so that you can decide whether you are able to fully complete the vision assessment. Please check the applicant's identity before you proceed.

The visual acuity, as measured by the 6 metre Snellen chart, must be at least 6/7.5 (decimal Snellen equivalent 0.8) in the better eye and at least Snellen 6/60 (decimal Snellen equivalent 0.1) in the other eye. Corrective lenses may be worn to achieve this standard. A LogMAR reading is acceptable.

If correction is needed to meet the eyesight standard for driving, ALL questions must be answered. If correction is NOT needed, questions 4 and 5 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.
Please convert any 3 metre readings to the 6 metre equivalent.

Uncorrected		**Corrected** (Using the prescription worn for driving)	
R	L	R	L

3. Please give the best binocular acuity (with corrective lenses if worn for driving). ☐

4. If glasses were worn, was the distance spectacle prescription of either lens used of a corrective power greater than plus 8 (+8) dioptres? **YES** ☐ **NO** ☐

5. If a correction is worn for driving, is it well tolerated? ☐ ☐

If you answer Yes to ANY of the following, give details in the box provided.

6. Is there a history of any medical condition that may affect the applicant's binocular field of vision (central and/or peripheral)? ☐ ☐

7. Is there diplopia? ☐ ☐

(a) Is it controlled? ☐ ☐

If **Yes**, please ensure you give full details in the box provided

8. Is there any reason to believe that there is impairment of contrast sensitivity or intolerance to glare? ☐ ☐

9. Does the applicant have any other ophthalmic condition? ☐ ☐

Details

Date of examination D D M M Y Y

Name (print)

Signature

Date of signature D D M M Y Y

Please provide your GOC, HPC or GMC number

Doctor/optometrist/optician's stamp

Applicant's full name **Date of birth** D D M M Y Y

Please do not detach this page

Medical Examination Report
Medical Assessment

Must be filled in by a doctor

- Please check the applicant's identity before you proceed.
- Please ensure you fully examine the applicant as well as taking the applicant's history.
- Please answer all questions, and read the notes in the Guidance leaflet attached (Information and useful notes) to help you complete this form

Section 1 – Nervous system

Please tick ✓ the appropriate box(es) YES NO

1. Has the applicant had any form of seizure? ☐ ☐

If **NO**, please go to **question 2 below**
If **YES**, please answer questions (a)–(f)

(a) Has the applicant had more than one attack? ☐ ☐

(b) Please give date of first and last attack

First attack D D M M Y Y

Last attack D D M M Y Y

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

If **YES**, please fill in current medication in **section 8**

(d) If no longer treated, please give date when treatment ended D D M M Y Y

(e) Has the applicant had a brain scan? ☐ ☐

If **YES**, please give details in **section 6**

(f) Has the applicant had an EEG? ☐ ☐

If **YES** to any of above, please supply reports if available.

2. Is there a history of blackout or impaired consciousness within the last 5 years? ☐ ☐

If **YES**, please give date(s) and details in **section 6**

3. Does the applicant suffer from narcolepsy or cataplexy? ☐ ☐

If **YES**, please give date(s) and details in **section 6**

4. Is there a history of, or evidence of **ANY** conditions listed at (a)–(h)? ☐ ☐

If **NO**, go to **section 2**
If **YES**, please give full details at **section 6** and supply relevant reports

(a) Stroke or TIA ☐ ☐

If **YES**, please give date D D M M Y Y

Has there been a **full** recovery? ☐ ☐

Has a carotid ultra sound been undertaken? ☐ ☐

(b) Sudden and disabling dizziness/vertigo within the last year with a liability to recur ☐ ☐

(c) Subarachnoid haemorrhage ☐ ☐

(d) Serious traumatic brain injury within the last 10 years ☐ ☐

(e) Any form of brain tumour ☐ ☐

(f) Other brain surgery or abnormality ☐ ☐

(g) Chronic neurological disorders ☐ ☐

(h) Parkinson's disease ☐ ☐

Section 2 – Diabetes mellitus

YES NO

1. Does the applicant have diabetes mellitus? ☐ ☐

If **NO**, please go to section 3
If **YES**, please answer the following questions.

2. Is the diabetes managed by:

(a) Insulin? ☐ ☐

If **YES** to Q2(a), please give date started on insulin

D D M M Y Y

(b) If treated with insulin, are there at least 3 months of blood glucose readings stored on a memory meter(s)? ☐ ☐

If **NO** to Q2(b) please give details in **section 6**

(c) Other injectable treatments? ☐ ☐

(d) A Sulphonylurea or a Glinide? ☐ ☐

(e) Oral hypoglycaemic agents and diet? ☐ ☐

If **YES** to any of Q2(a-e), please fill in current medication in **section 8**

(f) Diet only? ☐ ☐

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

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

4. Is there any evidence of impaired awareness of hypoglycaemia? ☐ ☐

5. Is there a history of hypoglycaemia in the last 12 months requiring the assistance of another person? ☐ ☐

6. Is there evidence of:-

(a) Loss of visual field? ☐ ☐

(b) Severe peripheral neuropathy, sufficient to impair limb function for safe driving? ☐ ☐

If **YES** to any of 4–6 above, please give details in **section 6**

7. Has there been laser treatment or intra-vitreal treatment for retinopathy? ☐ ☐

If **YES**, please give date(s) of treatment.

Applicant's full name _____ **Date of birth** D D M M Y Y

Section 3 – Psychiatric illness

Is there a history of, or evidence of, **ANY** of the conditions listed at 1– 7 below?

- Please enclose relevant hospital notes
- If applicant remains under specialist clinic(s), ensure details are filled in at section 7.

	YES	NO
1. Significant psychiatric disorder within the past 6 months	☐	☐
2. Psychosis or hypomania/mania within the past 3 years, including psychotic depression	☐	☐
3. Dementia or cognitive impairment	☐	☐
4. Persistent alcohol misuse in the past 12 months	☐	☐
5. Alcohol dependence in the past 3 years	☐	☐
6. Persistent drug misuse in the past 12 months	☐	☐
7. Drug dependence in the past 3 years	☐	☐

If YES to ANY of questions 4-7, please state how long this has been controlled

Please give details of past consumption or name of drug(s) and frequency

Section 4 – Cardiac

4A Coronary artery disease

Is there a history of, or evidence of, coronary artery disease? YES ☐ NO ☐

If **NO**, go to **section 4B**

If **YES**, please answer all questions below and give details at **section 6** of the form and enclose relevant hospital notes.

1. Has the applicant suffered from Angina? ☐ ☐

If **YES**, please give the date of the last known attack D D M M Y Y

2. Acute coronary syndromes including Myocardial infarction? ☐ ☐

If **YES**, please give date D D M M Y Y

3. Coronary angioplasty (P.C.I.) ☐ ☐

If **YES**, please give date of most recent intervention D D M M Y Y

4. Coronary artery by-pass graft surgery? ☐ ☐

If **YES**, please give date D D M M Y Y

Section 4B – Cardiac arrhythmia

Is there a history of, or evidence of, cardiac arrhythmia? YES ☐ NO ☐

If **NO**, go to **section 4C**

If **YES**, please answer all questions below and give details in **section 6**

1. Has there been a **significant** disturbance of cardiac rhythm? i.e. Sinoatrial disease, significant atrio-ventricular conduction defect, atrial flutter/fibrillation, narrow or broad complex tachycardia in the last 5 years ☐ ☐

2. Has the arrhythmia been controlled satisfactorily for at least 3 months? ☐ ☐

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

4. Has a pacemaker been implanted? ☐ ☐

If **YES**:-

(a) Please supply date of implantation D D M M Y Y

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

(c) Does the applicant attend a pacemaker clinic regularly? ☐ ☐

Section 4C – Peripheral arterial disease (excluding Buerger's disease) aortic aneurysm/dissection

Is there a history of, or evidence of, **ANY** of the following:

If **YES**, please give details in **section 6**

	YES	NO
1. Peripheral arterial disease (excluding Buerger's disease)	☐	☐
2. Does the applicant have claudication?	☐	☐

If **YES**, how long in minutes can the applicant walk at a brisk pace before being symptom-limited?

Please give details

3. Aortic aneurysm ☐ ☐

If **YES** to Q3:

(a) Site of Aneurysm: Thoracic ☐ Abdominal ☐

(b) Has it been repaired successfully? ☐ ☐

(c) Is the transverse diameter **currently** > 5.5 cm? ☐ ☐

If **NO** to Q3(c) please provide latest measurement and date obtained

D D M M 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.

5. Is there a history of Marfan's syndrome? ☐ ☐

If **YES**, provide relevant hospital notes

Applicant's full name **Date of birth** D D M M Y Y

Section 4D – Valvular/congenital heart disease

Is there a history of, or evidence of, valvular/congenital heart disease? YES ☐ NO ☐

If **NO**, go to **section 4E**

If **YES**, please answer all questions below and give details in **section 6** of the form.

1. Is there a history of congenital heart disorder? ☐ ☐

2. Is there a history of heart valve disease? ☐ ☐

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

4. Does the applicant currently have significant symptoms? ☐ ☐

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

Section 4E – Cardiac other

Does the applicant have a history of **ANY** of the following conditions:

If **YES**, please give details in **section 6**

	YES	NO
(a) a history of, or evidence of, heart failure?	☐	☐
(b) established cardiomyopathy?	☐	☐
(c) has a Left Ventricular Assist Device (LVAD) been implanted?	☐	☐
(d) a heart or heart/lung transplant?	☐	☐
(e) untreated atrial myxoma	☐	☐

Section 4F – Cardiac investigations

This section must be filled in for all applicants

1. Has a resting ECG been undertaken? YES ☐ NO ☐

   If **YES**, does it show:-

   (a) pathological Q waves? ☐ ☐

   (b) left bundle branch block? ☐ ☐

   (c) right bundle branch block? ☐ ☐

   If **yes** to a, b or c please comment at **section 6**

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

If **YES**, please give date and give details in **section 6** D D M M Y Y

Please provide relevant reports if available

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

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

Please provide relevant reports if available

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

If **YES**, please give date and give details in **section 6** D D M M Y Y

Please provide relevant reports if available

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

If **YES**, please give date and give details in **section 6** D D M M Y Y

Please provide relevant reports if available

6. Has a myocardial perfusion scan or stress echo study been undertaken (or planned)? ☐ ☐

If **YES**, please give date and give details in **section 6** D D M M Y Y

Please provide relevant reports if available

Section 4G – Blood pressure

1. Please record today's blood pressure reading ☐

2. Is the applicant on anti-hypertensive treatment? YES ☐ NO ☐

If **YES** provide three previous readings with dates if available

☐ D D M M Y Y

☐ D D M M Y Y

☐ D D M M Y Y

Applicant's full name ☐ **Date of birth** D D M M Y Y

Section 5 – General

Please answer **ALL** questions. If '**YES**' to any give full details in **section 6.**

	YES	NO
1. Is there currently any functional impairment that is likely to affect control of the vehicle?	☐	☐
2. Is there a history of bronchogenic carcinoma or other malignant tumour with a significant liability to metastasise cerebrally?	☐	☐
3. Is there any illness that may cause significant fatigue or cachexia that affects safe driving?	☐	☐
4. Is the applicant profoundly deaf?	☐	☐
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?	☐	☐
5. Does the applicant have a history of liver disease of any origin?	☐	☐
If **YES**, please give details in **section 6**		
6. Is there a history of renal failure?	☐	☐
If **YES**, please give details in **section 6**		
7. (a) Is there a history of, or evidence of, obstructive sleep apnoea syndrome?	☐	☐
(b) Is there any other **medical condition** causing excessive daytime sleepiness?	☐	☐

If **YES**, please give diagnosis

If **YES**, to 7a or b please give

(i) Date of diagnosis D D M M Y Y

(ii) Is it controlled successfully? ☐ ☐

(iii) If **YES**, please state treatment

(iv) Please state period of control

(v) Date last seen by consultant D D M M Y Y

8. Does the applicant have severe symptomatic respiratory disease causing chronic hypoxia?	☐	☐
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**		
10. Does the applicant have an ophthalmic condition?	☐	☐
If **YES**, please provide details in **section 6**		
11. Does the applicant have any other medical condition that could affect safe driving?	☐	☐
If **YES**, please provide details in **section 6**		

Section 6 – Further details

Please attach copies of relevant hospital notes.

PLEASE DO NOT send any notes not related to fitness to drive.

Applicant's full name

Date of birth D D M M Y Y

Section 7 – Consultants' details

Details of type of specialist(s)/consultants, including address.

Consultant in
Name
Address

Date of last appointment D D M M Y Y

Consultant in
Name
Address

Date of last appointment D D M M Y Y

Consultant in
Name
Address

Date of last appointment D D M M Y Y

Section 8 – Medication

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

Medication	Dosage
Reason for taking:	

Medication	Dosage
Reason for taking:	

Medication	Dosage
Reason for taking:	

Medication	Dosage
Reason for taking:	

Section 9 – Additional information

Patient's weight (kg)

Height (cms)

Details of smoking habits, if any

Number of alcohol units taken each week

Examining doctor's details

To be filled in by doctor carrying out the examination

Please ensure all sections of the form have been completed. Failure to do so will result in the form being rejected.

I CERTIFY THAT:

a) I have full knowledge of the applicants past medical history **and**

b) I have this day examined the applicant, who has signed this form in my presence and who in my opinion, with regard to the Vocational Licence (Group 2) guidelines issued by the DVLA and the Medical Commission for Accident Prevention is

☐ **MEDICALLY FIT*** to drive a Hackney Carriage or Private Hire Vehicle

☐ **MEDICALLY UNFIT*** to drive a Hackney Carriage or Private Hire Vehicle

**** Please select the appropriate box***

Section 10 – Doctor's details

(please print name and address in capital letters)

Surgery stamp

GMC registration number

Signature of medical practitioner

Date of examination D D M M Y Y

IMPORTANT

Please make sure the FIT/UNFIT declaration above has been completed. Failure to do this will result in the medical form not being accepted and the applicant will be asked to return to the surgery.

Applicant's full name **Date of birth** D D M M Y Y

Applicant's details

To be filled-in in the presence of the doctor carrying out the examination

Please make sure that you have printed your name and date of birth on each page before sending this form with your application

Section 11 – Your details

Your full name
Your address
Email address

Date of birth D D M M Y Y

Home phone number

Work/daytime number

Date when first licensed to drive a HC/PH vehicle D D M M Y Y

About your doctor/group practice

Doctor/group name
Address
Phone
Email address
Fax number

1. This certificate is not one which must be issued free of charge as part of the national health service
2. Please note that Walsall Council is not liable for the payment of any medical examination fees – these are the sole responsibility of the applicant.

Section 12 – Applicant's consent and declaration

Consent and declaration

This section **MUST** be filled in and must **NOT** be altered in any way.

Please read the following consent and declaration carefully then sign to confirm the statements below.

Consent and declaration

I authorise my doctor(s) and specialist(s) to release reports/ medical information about my condition relevant to my fitness to drive, to Walsall Council.

I declare that I have checked the details I have given on the enclosed questionnaire 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/private hire driving licence and can lead to prosecution.

Name

Signature

Date

Obligations on Licensed Taxi Drivers to Carry Guide, Hearing and Other Assistance Dogs – Medical Exemption.

The Government is committed to an accessible public transport system in which disabled people can enjoy the same opportunities to travel as other members of society. Taxis are a vital link in the accessible transport chain and it is important that disabled people who use guide, hearing or other assistance dogs can have confidence that the taxi they find on a rank, or hail on the street, will accept them and carry their dog at no extra charge.

Taxi drivers have a legal duty to carry guide, hearing or other prescribed assistance dogs, accompanying a disabled person who has hired his or her taxi and to do so without charge. These provisions are made under Section 37 of the Disability Discrimination Act 1995.

However, to enable drivers with certain medical conditions which are aggravated by exposure to dogs to drive or continue to drive taxis, the law includes provisions for drivers to be exempted from these duties on medical grounds.

Walsall Council is responsible for issuing exemption certificates and needs to be satisfied that it is appropriate to do so on medical grounds. In determining whether to issue an exemption certificate the Council will also have to consider the physical characteristics of the taxi driven by the applicant, e.g. whether the vehicle has a fixed partition segregating the driver from the passenger compartment.