

## MEDICAL REPORT – NOTES

### APPLICATION FOR HACKNEY CARRIAGE AND/OR PRIVATE HIRE DRIVER'S LICENCE

#### (Please hand these notes and examination form to your Doctor)

All medicals must be completed by a General Practitioner at your registered surgery/practice. Your doctor will be required to confirm that they have sight of your medical records.

**Please note that during the coronavirus (COVID-19) pandemic, the licensing authority will permit Medical Reports to be completed by a doctor other than your General Practitioner at your registered surgery/practice, where there is difficulty obtaining an appointment. This third-party doctor must have access to a summary of your medical records, provided by your registered surgery/practice.**

This form is required to be completed for all new applicants for hackney carriage and/or private hire driver's licences, then every five years until you are 65 years old, and annually thereafter. The Council may also request a medical examination where they are satisfied that a condition has arisen which may affect the person's physical fitness to hold a licence.

#### **A What you have to do**

1. Before arranging for this medical report to be completed please read the notes at section C, paragraphs 1,2,3,4 and 5 (Group 2 Medical Standards). If you have any of these conditions you may not be granted a licence.
2. If, after reading the notes, you have any doubts about your ability to meet the medical standards, consult your doctor and/or Optician **before** you arrange for this medical report to be completed. In the event of your application being refused, the fee you pay your doctor is not refundable. Winchester City Council has no responsibility for the fee payable to your doctor.
3. In future, if you develop symptoms of a condition that could affect safe driving (see the notes at section C below), you must inform the City Council's Licensing Team immediately.
5. Sections 9 and 10 must be completed by you in the presence of the doctor.

#### **B What your Doctor has to do**

1. Please arrange for your patient to be seen and for a full examination to be undertaken.
2. Please complete **pages 5 to 15 inclusive**, having regard to the most recent BMA "Notes for Guidance" for Doctors conducting these examinations. The most recent edition of the Medical Commission for Accident Prevention's booklet "Medical Aspects of Fitness to Drive" (1985 edition) should be consulted in association with the latest edition of the Driver & Vehicle Licensing Agency's publication "Assessing fitness to drive: a guide for medical professionals" (available on the DVLA's website at: <https://www.gov.uk/guidance/assessing-fitness-to-drive-a-guide-for-medical-professionals>).
3. Applicants who may be symptom free at the time of the examination should be advised that, if, in future, they develop symptoms of a medical condition which could affect safe driving, and a hackney carriage and/or private hire driver's licence is held, Winchester City Council's Licensing Department must be informed immediately.

## C Medical Standards for Hackney Carriage and/or Private Hire Drivers

Standards for hackney carriage and/or private hire drivers, as vocational drivers, are higher than those for ordinary car drivers. In line with recommended good practice, the Council will expect licensed drivers to meet the Group 2 vocational driver standards.

The DVLA have provided useful guidance notes (INF4D) about the Group 2 medical examination standards which is available here:

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/492335/INF4D\\_091115.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/492335/INF4D_091115.pdf)

Specific medical conditions which will be a bar to obtaining or holding a hackney carriage and/or private hire driver's licence are as follows: -

### 1. Epilepsy or liability to epileptic attacks

A diagnosis of epilepsy or spontaneous epileptic attack(s) requires 10 years free of further epileptic attack without taking anti-epilepsy medication during that 10-year period. For conditions that cause an increased liability to epileptic attacks, the risk of attacks must fall to that of the general population. The City Council will refuse or revoke the licence if these conditions cannot be met.

### 2. Diabetes mellitus

The council will consider the grant or renewal of driver licences for insulin treated diabetes subject to the following:

- No episodes of hypoglycaemia whilst driving in the last 12 months;
- Arrangements are in place to see a hospital consultant specialising in the treatment of diabetes every 12 months; and
- A consultant's report with a history of responsible diabetic control and evidence of blood glucose records for 3 months must be produced. A glucose meter with a memory function to measure and record blood glucose levels must be used.

### 3. Eyesight

All applicants must be able to read in good light with glasses or corrective lenses if necessary, a number plate at 20.5 metres (67 feet) or 20 metres (65 feet), where narrower characters are displayed (50 mm wide). The characters displayed on all new and replacement number plates manufactured from September 2001 are 50 mm in width instead of 57 mm. and, if glasses or contact lenses are required to do so, these must be worn while driving. In addition -

#### (i) Applicants must have:

- A visual acuity of at least 6/7.5 in one eye; and
- A visual acuity of at least 6/60 in the other eye; and
- If these are achieved by correction the **uncorrected** visual acuity in each eye must be no less than 3/60.

If you cannot meet the above standard you may still be able to satisfy the medical standards if:

- You held a driver licence before 01 January 1997
- You have a corrected visual acuity of at least 6/9 (decimal Snellen equivalent 0.6) in the better eye and 6/12 (decimal Snellen equivalent 0.5) in the worse eye **and**
- An uncorrected visual acuity of 3/60 (decimal Snellen equivalent 0.05) in at least one eye

or -

- You held a driver licence on 01 March 1992
- You have a corrected visual acuity of at least 6/12 (decimal Snellen equivalent 0.5) using both eyes together
- You have an uncorrected visual acuity of at least 3/60 (decimal Snellen equivalent 0.05) in at least one eye

## **(ii) Visual field**

The horizontal visual field should be at least 160 degrees. The extension should be at least 70 degrees left and right and 30 degrees up and down. No defects should be present within a radius of the central 30 degrees.

## **(iii) Monocular vision**

Persons who have sight in one eye only or their sight in one eye has deteriorated to a corrected acuity of less than 3/60 (decimal Snellen equivalent 0.05) cannot normally be licensed **unless** they were licensed prior to April 1991 and the council knew you had sight in only one eye before January 1991.

## **(iv) Uncontrolled symptoms of double vision**

Uncontrolled symptoms of double vision preclude licensing. As monocular vision is a bar, the treatment for double vision with a patch will not meet the Group 2 standard.

**Please note that a failure to meet the epilepsy, diabetes or eyesight requirements will normally result in the refusal of an application.**

## **4. Other medical conditions**

In addition to those medical conditions mentioned above, an applicant or licence holder is likely to be refused if they are unable to meet the national recommended guidelines in cases of -

- Within six weeks of myocardial infarction, an episode of unstable angina or coronary angioplasty;
- Within three months of coronary artery bypass graft (CABG);
- Angina, heart failure or cardiac arrhythmia which remains uncontrolled;
- Implanted cardiac defibrillator;
- Hypertension where the blood pressure is persistently 180 systolic or more or 100 diastolic or more;
- Within 12 months of a stroke, transient ischaemic attack (TIA);
- Unexplained loss of consciousness with liability to reoccur;
- Meniere's disease and other sudden and disabling vertigo, within the last 12 months, with a liability to reoccur;
- Insuperable difficulty in communicating by telephone (or textphone) in an emergency;
- Major brain surgery and/or recent severe head injury with serious continuing after effects;
- Parkinson's disease, multiple sclerosis or other chronic neurological disorders likely to affect safe driving;
- Psychotic illness within the past three years;
- Serious psychiatric illness;
- If major psychotropic or neuroleptic medication is being taken;
- Alcohol and/or drug misuse within the last three years or alcohol and/or drug dependency or use in the past six years;
- Dementia;
- Any malignant condition, within the last two years, with a significant liability to metastasise to the brain;
- Any other serious medical condition likely to affect the safe driving of a hackney carriage and/or private hire vehicle.

## **5. Sleep disorders**

Up to one fifth of accidents on motorways and other monotonous roads may be caused by drivers falling asleep at the wheel.

Many accidents are attributed to "driver inattention" but once vehicle faults, traffic offences, poor road or weather conditions, alcohol and specific medical causes are excluded, closer inspection suggests driver sleepiness may be the cause. Evidence for this includes the apparent failure to respond to traffic and road conditions generally and, in particular, the absence of signs of emergency braking.

Driver sleepiness may be caused by modern life styles preventing adequate rest. It may be made worse by shift working combined with the monotonous nature of certain types of driving. Alertness fluctuates naturally throughout the day. Driving between 02:00 and 07:00 increases the risk of a

sleep related accident. Most people also tend to be less alert during the mid-afternoon or after a heavy meal. All drivers need to address these problems responsibly.

However, some medical conditions may cause excessive sleepiness. These will greatly increase any normal tendency to sleepiness.

The most common medical cause is **Obstructive Sleep Apnoea Syndrome (OSA)**. This condition occurs most commonly, but not exclusively, in overweight individuals, particularly those with a large collar size. Partners often complain about the snoring and notice that sufferers seem to have irregular breathing during sleep. Sufferers of OSA rarely wake from sleep feeling fully refreshed and tend to fall asleep easily when relaxing.

OSA is one of the few medical conditions that has been shown to increase significantly the risk of traffic accidents. However, once diagnosed, there is very effective treatment available, normally through specialist centres.

The greatest danger is prior to diagnosis, when the significance of the symptoms is not appreciated. A road traffic accident may be the first clear indication of the condition. All drivers, especially professional drivers, and doctors need to be much more aware of the risks of sleepiness from this treatable cause.



Winchester  
City Council

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## MEDICAL EXAMINATION

### APPLICATION FOR HACKNEY CARRIAGE AND/OR PRIVATE HIRE DRIVER'S LICENCE

This must be completed by your Doctor, taking into account the criteria for Group 2 vocational drivers as set out in "Medical Aspects of Fitness to Drive" and the latest edition of the DVLA publication "Assessing fitness to drive: a guide for medical professionals".

**Please answer all questions and use black ink throughout**

Applicant's weight (kg/st)		Applicant's height (cm/ft)	
Please give details of smoking habits, if any			
Please give number of alcohol units taken each week			

Details of specialist(s) / consultant(s)		
Name	Speciality	Date last seen

*If more space required, use Section 7*

Current medication

*If more space required, use Section 7*

Date first licensed to drive a hackney carriage and/or private hire vehicle	
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### Section 1 – Vision *(please see eyesight notes on page 2)*

**Please tick ✓ the appropriate boxes**

	Yes	No
1. Is the visual acuity <b>at least</b> 6/7.5 in one eye and at least 6/60 in the other eye (corrective lenses may be worn) as measured by the Snellen chart?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do corrective lenses have to be worn to achieve this standard?	<input type="checkbox"/>	<input type="checkbox"/>
If <b>Yes</b> , is the		
(a) uncorrected acuity at least 3/60 in the right eye?	<input type="checkbox"/>	<input type="checkbox"/>
(b) uncorrected acuity at least 3/60 in the left eye?	<input type="checkbox"/>	<input type="checkbox"/>
<b>(3/60 being the ability to read the 6/60 line of the full size 6 metre Snellen chart at 3 metres)</b>		
(c) correction well tolerated?	<input type="checkbox"/>	<input type="checkbox"/>
3. Please state all the visual acuities of each eye in terms of the 6 metre Snellen chart. Please convert any 3 metre readings to the 6 metre equivalent		

Uncorrected			
Right		Left	

Corrected (if applicable)			
Right		Left	

Applicant's name		DOB	
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		Yes	No
4.	Is there a defect in their binocular field of vision? (central and peripheral)	<input type="checkbox"/>	<input type="checkbox"/>
5.	Is there diplopia (controlled or uncontrolled)?	<input type="checkbox"/>	<input type="checkbox"/>
6.	Does the applicant report symptoms of any of the following that impairs their ability to drive? ( <b>Please indicate below and give full details in section 8</b> )		
	(a) Intolerance to glare (causing incapacity rather than discomfort) and/or	<input type="checkbox"/>	<input type="checkbox"/>
	(b) Impaired contrast sensitivity and/or	<input type="checkbox"/>	<input type="checkbox"/>
	(c) Impaired twilight vision	<input type="checkbox"/>	<input type="checkbox"/>
7.	Does the applicant have any other ophthalmic condition?	<input type="checkbox"/>	<input type="checkbox"/>
If <b>Yes</b> to questions 4, 5, 6 or 7, please give details in <b>section 8</b> and enclose any relevant visual field charts or hospital letters.			

## Section 2 – Neurological disorders

*Please tick ✓ the appropriate boxes*

		Yes	No
1.	Has the applicant had any form of seizure?	<input type="checkbox"/>	<input type="checkbox"/>
	(a) Has the applicant had more than one attack?	<input type="checkbox"/>	<input type="checkbox"/>
	(b) If <b>Yes</b> , please provide date of first and last attack in <b>section 8</b> .		
	(c) Is the applicant currently on anti-epileptic medication? If <b>Yes</b> , please provide details in <b>section 8</b> .	<input type="checkbox"/>	<input type="checkbox"/>
	(d) If no longer treated or taking medication, when did this end? (Give date)		
	(e) Has the applicant had a brain scan? If <b>Yes</b> , please provide details in <b>section 8</b> .	<input type="checkbox"/>	<input type="checkbox"/>
	(f) Has the applicant had an EEG? If <b>Yes</b> , please provide details in <b>section 8</b> .	<input type="checkbox"/>	<input type="checkbox"/>
2.	Has the applicant had an episode(s) of non-epileptic attack disorder?	<input type="checkbox"/>	<input type="checkbox"/>
	(a) If <b>Yes</b> , please provide dates and details in <b>section 8</b> .		
	(b) If <b>Yes</b> , have any of these episode(s) occurred or are they considered likely to occur whilst driving?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Stroke or TIA? If <b>Yes</b> , please give the date	<input type="checkbox"/>	<input type="checkbox"/>
	(a) Has there been a <b>full</b> recovery?	<input type="checkbox"/>	<input type="checkbox"/>
	(b) Is there a history of multiple strokes / TIAs?	<input type="checkbox"/>	<input type="checkbox"/>
4.	Is there any history, or evidence of any conditions listed at (a) to (g) below? If <b>No</b> , go to <b>section 3</b> .	<input type="checkbox"/>	<input type="checkbox"/>
	(a) Sudden and disabling dizziness/vertigo within the last year with a liability to recur?	<input type="checkbox"/>	<input type="checkbox"/>
	(b) Subarachnoid haemorrhage?	<input type="checkbox"/>	<input type="checkbox"/>
	(c) Serious traumatic brain injury within the last 10 years?	<input type="checkbox"/>	<input type="checkbox"/>

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		Yes	No
(d)	Any form of brain tumour?	<input type="checkbox"/>	<input type="checkbox"/>
(e)	Other brain surgery or abnormality?	<input type="checkbox"/>	<input type="checkbox"/>
(f)	Chronic neurological disorder e.g. Parkinson's disease, Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
(g)	Blackout or impaired consciousness within the last 10 years?	<input type="checkbox"/>	<input type="checkbox"/>

### Section 3 – Diabetes Mellitus

*Please tick ✓ the appropriate boxes*

		Yes	No
1.	Does the applicant have diabetes mellitus? If <b>No</b> , go to <b>section 4</b> . If <b>Yes</b> , please answer the questions below.	<input type="checkbox"/>	<input type="checkbox"/>
2.	Is the diabetes managed by -		
	(a) Insulin? If yes, please give date started on insulin	<input type="checkbox"/>	<input type="checkbox"/>
	(b) Other injectable treatments?	<input type="checkbox"/>	<input type="checkbox"/>
	(c) Oral hypoglycaemic agents and diet?	<input type="checkbox"/>	<input type="checkbox"/>
	(d) Diet only?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Does the applicant test blood glucose at least twice every day?	<input type="checkbox"/>	<input type="checkbox"/>
	(a) Does the applicant test at times relevant to driving (no more than 2 hours before the start of the first journey and every 2 hours while driving?)	<input type="checkbox"/>	<input type="checkbox"/>
	(b) Does the applicant keep fast-acting carbohydrate within easy reach when driving?	<input type="checkbox"/>	<input type="checkbox"/>
4.	Is there evidence of -		
	(a) Loss of visual field?	<input type="checkbox"/>	<input type="checkbox"/>
	(b) Severe peripheral neuropathy, sufficient to impair limb function for safe driving?	<input type="checkbox"/>	<input type="checkbox"/>
	(c) Diminished awareness of hypoglycaemia?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Is there a history of hypoglycaemia in the last 12 months requiring the assistance of another person? If <b>Yes</b> , please provide details in <b>section 8</b> .	<input type="checkbox"/>	<input type="checkbox"/>
6.	Has there been laser treatment or intra-vitreous treatment for retinopathy? If <b>Yes</b> , please give date(s) of treatment	<input type="checkbox"/>	<input type="checkbox"/>
7.	If <b>Yes</b> to any of 4-6 above, please give details in <b>section 8</b> .		

Applicant's name		DOB	
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## Section 4 – Psychiatric illness

Please tick ✓ the appropriate boxes

		Yes	No
1.	Is there a history, or evidence, of any of the condition listed at (a) to (f) below? If <b>No</b> , go to <b>section 5</b> . If <b>Yes</b> , please tick the relevant box(es) below and give dates, prognosis, period of stability and details of medication, dosage and any side effects in <b>section 8</b> . <b>NB</b> if applicant remains under specialist clinic(s), ensure details are entered on front page.	<input type="checkbox"/>	<input type="checkbox"/>
(a)	Significant psychiatric disorder within the past 6 months e.g. depression	<input type="checkbox"/>	<input type="checkbox"/>
(b)	Psychosis or hypomania/mania within the past 12 months, including psychotic depression	<input type="checkbox"/>	<input type="checkbox"/>
(c)	Persistent alcohol misuse in the past 3 years	<input type="checkbox"/>	<input type="checkbox"/>
(d)	A history of alcohol dependence in the past 6 years	<input type="checkbox"/>	<input type="checkbox"/>
(e)	Persistent misuse of drugs or other substances in the past 3 years	<input type="checkbox"/>	<input type="checkbox"/>
(f)	A history of drug (or other substance) dependence in the past 6 years	<input type="checkbox"/>	<input type="checkbox"/>

## Section – - Cardiac

Please follow the instructions in all sections **5A – 5G** giving details are required in **section 8**.

**NB** if applicant remains under specialist cardiac clinic(s), ensure details are entered on front page.

## Section 5A – Coronary artery disease

Please tick ✓ the appropriate boxes

		Yes	No
	Is there a history, or evidence, or coronary artery disease? If <b>No</b> , go to <b>section 5B</b> . If <b>Yes</b> please answer all questions below and give details in <b>section 8</b> .	<input type="checkbox"/>	<input type="checkbox"/>
1.	Has the applicant suffered from Angina? If <b>Yes</b> , give date of last attack	<input type="checkbox"/>	<input type="checkbox"/>
2.	Acute coronary syndrome including myocardial infarction If <b>Yes</b> , please give date(s)	<input type="checkbox"/>	<input type="checkbox"/>
3.	Coronary angioplasty (PCI) If <b>Yes</b> , please give date of most recent intervention	<input type="checkbox"/>	<input type="checkbox"/>
4.	Coronary artery bypass graft surgery? If <b>Yes</b> , please give date(s)	<input type="checkbox"/>	<input type="checkbox"/>

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## Section 5B – Cardiac arrhythmia

Please tick ✓ the appropriate boxes

	Yes	No
Is there any history, or evidence, of cardiac arrhythmia?	<input type="checkbox"/>	<input type="checkbox"/>
If <b>No</b> , go to <b>section 5C</b> .		
If <b>Yes</b> please answer all questions below and give details in <b>section 8</b> .		
1. Has the applicant had a significant documented disturbance in cardiac rhythm within the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>
2. Has the arrhythmia been controlled satisfactorily for at least 3 months?	<input type="checkbox"/>	<input type="checkbox"/>
3. Has a cardiac defibrillator device been implanted?	<input type="checkbox"/>	<input type="checkbox"/>
4. Has a pacemaker been implanted?	<input type="checkbox"/>	<input type="checkbox"/>
If <b>Yes</b> -		
(a) Has the pacemaker been implanted for at least 6 weeks?	<input type="checkbox"/>	<input type="checkbox"/>
(b) Is the applicant free of the symptoms that caused the device to be fitted?	<input type="checkbox"/>	<input type="checkbox"/>
(c) Does the applicant attend a pacemaker clinic regularly?	<input type="checkbox"/>	<input type="checkbox"/>

## Section 5C – Peripheral arterial disease

Please tick ✓ the appropriate boxes

	Yes	No
Is there any history, or evidence, of any of the following?	<input type="checkbox"/>	<input type="checkbox"/>
If <b>No</b> , go to <b>section 5D</b> .		
If <b>Yes</b> please answer all questions below and give details in <b>section 8</b> .		
1. Peripheral arterial disease	<input type="checkbox"/>	<input type="checkbox"/>
2. Aortic aneurysm	<input type="checkbox"/>	<input type="checkbox"/>
If <b>Yes</b> -		
(a) Site of the aneurysm -		
(i) Thoracic	<input type="checkbox"/>	<input type="checkbox"/>
(ii) Abdominal	<input type="checkbox"/>	<input type="checkbox"/>
(b) Has it been repaired successfully?	<input type="checkbox"/>	<input type="checkbox"/>
(c) Is the transverse diameter more than 5cm?	<input type="checkbox"/>	<input type="checkbox"/>
3. Dissection of the aorta?	<input type="checkbox"/>	<input type="checkbox"/>
If <b>Yes</b> , has it been repaired successfully?	<input type="checkbox"/>	<input type="checkbox"/>
4. History of Marfan's disease?	<input type="checkbox"/>	<input type="checkbox"/>
If <b>Yes</b> , please provide hospital notes in <b>section 8</b> .		

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## Section 5D – Valvular / congenital heart disease

Please tick ✓ the appropriate boxes

	Yes	No
Is there any history, or evidence, of valvular / congenital heart disease?	<input type="checkbox"/>	<input type="checkbox"/>
If <b>No</b> , go to <b>section 5E</b> .		
If <b>Yes</b> please answer all questions below and give details in <b>section 8</b> .		
1. Is there a history of congenital heart disease?	<input type="checkbox"/>	<input type="checkbox"/>
2. Is there a history of heart valve disease?	<input type="checkbox"/>	<input type="checkbox"/>
3. Is there a history or aortic stenosis?	<input type="checkbox"/>	<input type="checkbox"/>
4. Is there a history of embolism ( <b>not pulmonary</b> embolism)?	<input type="checkbox"/>	<input type="checkbox"/>
5. Does the applicant currently have significant symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
6. Has there been any progression since the last licence application (if relevant)?	<input type="checkbox"/>	<input type="checkbox"/>

## Section 5E – Cardiac other

Please tick ✓ the appropriate boxes

	Yes	No
Is there any history, or evidence, of the following conditions?	<input type="checkbox"/>	<input type="checkbox"/>
If <b>No</b> , go to <b>section 5F</b> .		
If <b>Yes</b> please answer all questions below and give details in <b>section 8</b> .		
1. A history, or evidence, of heart failure	<input type="checkbox"/>	<input type="checkbox"/>
2. Established cardiomyopathy	<input type="checkbox"/>	<input type="checkbox"/>
3. Has a left ventricular assist device (LVAD) or other cardiac assist device been implanted?	<input type="checkbox"/>	<input type="checkbox"/>
4. A heart or heart/lung transplant	<input type="checkbox"/>	<input type="checkbox"/>
5. Untreated atrial myxoma	<input type="checkbox"/>	<input type="checkbox"/>
6. Brugada syndrome	<input type="checkbox"/>	<input type="checkbox"/>
7. Long QT syndrome	<input type="checkbox"/>	<input type="checkbox"/>

## Section 5F – Cardiac investigations

This section must be completed for all applicants

Please tick ✓ the appropriate boxes

	Yes	No
1. Has a resting ECG been undertaken?	<input type="checkbox"/>	<input type="checkbox"/>
If <b>Yes</b> , does it show -		
(a) Pathological Q waves?	<input type="checkbox"/>	<input type="checkbox"/>
(b) Left bundle branch block?	<input type="checkbox"/>	<input type="checkbox"/>
(c) Right bundle branch block?	<input type="checkbox"/>	<input type="checkbox"/>
If <b>Yes</b> to (a), (b) or (c), please provide a copy of the ECG report in <b>section 8</b> .		
2. Has an exercise ECG been undertaken (or planned)?	<input type="checkbox"/>	<input type="checkbox"/>

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If **Yes**, give date and details in **section 8**.

*Sight/copy of the exercise test result/report (if done in the last 3 years) would be useful.*

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

If **Yes**, give date and details in **section 8**.

*Sight/copy of the echocardiogram result/report would be useful.*

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

If **Yes**, give date and details in **section 8**.

*Sight/copy of the angiogram result/report would be useful*

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

If **Yes**, give date and details in **section 8**.

*Sight/copy of the 24 hour tape result/report would be useful*

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

If **Yes**, give date and details in **section 8**.

7. Please provide the date last seen by a consultant specialist for any cardiac condition declared.

## Section 5G – Blood pressure

This section must be completed for all applicants

*Please tick ✓ the appropriate boxes*

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 1. Is today's systolic pressure greater than 180?                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Is today's diastolic pressure greater than 100?                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Is the applicant on anti-hypertensive treatment?                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. If <b>Yes</b> to any of the above, please provide today's reading. |                          |                          |

## Section 6 – Sleep disorders

*Please tick ✓ the appropriate boxes*

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**.

If **Yes** please answer all questions below and give details in **section 8**.

1. If Obstructive Sleep Apnoea Syndrome, please indicate the severity:
- |                               |                          |                          |
|-------------------------------|--------------------------|--------------------------|
| <b>Mild</b> (AHI <15)         | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Moderate</b> (AHI 15 – 29) | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Severe</b> (AHI >29)       | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Not known</b>              | <input type="checkbox"/> | <input type="checkbox"/> |

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2.	Please answer all questions for <b>all</b> sleep conditions		
(a)	Date of diagnosis		
(b)	Is it controlled successfully?	<input type="checkbox"/>	<input type="checkbox"/>
(c)	If <b>Yes</b> , please provide details of treatment in <b>section 8</b> .	<input type="checkbox"/>	<input type="checkbox"/>
(d)	Is applicant compliant with treatment?	<input type="checkbox"/>	<input type="checkbox"/>
(e)	Please provide date of last review		
3.	Is there a history, or evidence, or narcolepsy?	<input type="checkbox"/>	<input type="checkbox"/>

### Section 7 – General

Please answer all questions in this section. If your answer is **Yes**, please give full details in **section 8**.

*Please tick ✓ the appropriate boxes*

		Yes	No
1.	Is there currently any functional impairment that is likely to affect control of the vehicle? e.g. a disability of the spine or limbs	<input type="checkbox"/>	<input type="checkbox"/>
2.	Is there a history of bronchogenic carcinoma or other malignant tumour with a significant liability to metastasise cerebrally?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Is there any illness that may cause significant fatigue or cachexia that affects safe driving?	<input type="checkbox"/>	<input type="checkbox"/>
4.	Is the applicant profoundly deaf?	<input type="checkbox"/>	<input type="checkbox"/>
	If <b>Yes</b> , is the applicant able to communicate in the event of an emergency by speech or using a device e.g. a textphone?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Does the applicant have a history of liver disease of any origin?	<input type="checkbox"/>	<input type="checkbox"/>
6.	Is there a history of either renal or hepatic failure?	<input type="checkbox"/>	<input type="checkbox"/>
	If <b>Yes</b> , has it been controlled successfully?	<input type="checkbox"/>	<input type="checkbox"/>
7.	Does the applicant have severe symptomatic respiratory disease causing chronic hypoxia?	<input type="checkbox"/>	<input type="checkbox"/>
8.	Does any medication currently taken cause the applicant side effects that could affect safe driving? e.g. drowsiness	<input type="checkbox"/>	<input type="checkbox"/>
9.	Does the applicant have any other medical condition that could affect safe driving?	<input type="checkbox"/>	<input type="checkbox"/>

Applicant's name		DOB	
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## Section 8 – Additional information

Please provide further details as required, including relevant copies of hospital notes if available.



Winchester  
City Council

Applicant's name

DOB

## Section 9 – Applicant’s consent and declaration

**This section must be completed and must not be altered in any way.**

Please read the following important information carefully then sign and date the statements below.

On occasion, as part of the investigation into your fitness to drive a hackney carriage or private hire vehicle, Winchester City Council may require you to undergo a medical examination or some form of practical assessment. In these circumstances, those personnel involved will require your medical background details to undertake an appropriate and adequate assessment. Such personnel might include doctors, orthoptists at eye clinics or paramedical staff at a driving assessment centre. Only information relevant to the assessment of your fitness to drive will be released. In addition, where the circumstances of your case appear exceptional, the relevant medical information would need to be considered by members of the City Council’s Licensing Committee. Such information would be subject to legal restrictions on confidentiality.

### Consent and Declaration

I authorise my Doctor(s) and Specialist(s) to release reports to Winchester City Council as Licensing Authority about my condition(s).

I authorise Winchester City Council to disclose such relevant medical information as may be necessary to the investigation of my fitness to drive, to all those involved in the determination of my application for a licence, and to release to my Doctor(s) details of the outcome of my case and any relevant medical information.

I declare that I have checked the details I have given on this form and that, to the best of my knowledge and belief, they are correct.

Signature

Date

## Section 10 – Applicant’s details

**This section must be completed in the presence of the medical practitioner carrying out the examination.** Please ensure that you have printed your name and date of birth on each page before sending this form to the Licensing Department.

Full Name

Date of Birth

Address

Home Tel:

Mobile Tel:

Postcode

Applicant’s name

DOB

## Section 11 – Medical Practitioner’s details

To be completed by the medical practitioner carrying out the examination.

Full Name		Surgery Stamp
Address		
Postcode		

**IMPORTANT – Failure to answer the questions below will invalidate the medical report form.**

*Please tick ✓ the appropriate boxes*

	Yes	No
The applicant is registered with this surgery/practice as a patient	<input type="checkbox"/>	<input type="checkbox"/>
I have full access to the patient’s medical records	<input type="checkbox"/>	<input type="checkbox"/>
I am not the applicant’s registered GP but have seen a recent summary of their medical records ( <i>permitted during coronavirus (COVID-19) pandemic only</i> )	<input type="checkbox"/>	<input type="checkbox"/>
I consider that the applicant meets the criteria for Group 2 vocational driver’s licence as set out in the latest editions of the DVLA publication "Assessing fitness to drive: a guide for medical professionals" and the Medical Commission on Accident Prevention’s publication "Medical Aspects of Fitness to Drive".	<input type="checkbox"/>	<input type="checkbox"/>

Practitioner Signature		Date	
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Applicant’s name		DOB	
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