

MEDICAL CERTIFICATE ASSOCIATED WITH AN APPLICATION FOR A LICENCE TO DRIVE A HACKNEY CARRIAGE OR PRIVATE HIRE VEHICLE

Applicant's details: (please complete)

Full name: **Date of Birth:**.....

Current address:
.....
.....
.....

Applicant's consent and declaration:

(Please read the following carefully before signing and dating the declaration).

I authorise my General Practitioner(s) and Specialist(s) to release medical information about my condition, together with any relevant information relevant to fitness to drive, to the Licensing Section, Newcastle City Council for the purpose of the Council (by its Officers and/or Members) of assessing my fitness to drive a hackney carriage or private hire vehicle licensed by that Council.

I declare that to the best of my knowledge and belief all information given by me to my doctors in connection with the examination or the completion of the DVLA Group 2 medical examination report are true. In the event that the Council is not satisfied of my fitness to drive a hackney carriage or private hire vehicle, I confirm that I may, at my own cost, submit such further medical evidence to the Council as I consider appropriate.

Signed:.....**Date:**.....

TO THE G.P. This form must be completed in full by the applicant's own G.P. or a medical practitioner who has reviewed the applicant's medical records. Please answer all questions and once completed sign the declaration at the end.

The Councils' policy on medical fitness requires that taxi drivers meet Group 2 Entitlement, as set out in the DVLA publication 'A Guide to the current Medical Standards of Fitness to Drive'. This guide makes reference to current best practice guidance contained in the booklet 'Fitness to Drive' which recommends the medical standard applied by DVLA in relation to bus and lorry drivers should also be applied by local authorities to taxi drivers.

(a)	<p>Is the applicant a registered patient of the surgery / medical centre at which you practice as a registered medical practitioner?</p> <p>If NO please provide details of patient's registered GP and surgery. Doctor's Name: Address:</p>	YES	NO
(b)	<p>Have you reviewed the above applicant's medical records?</p>	YES	NO

1. VISION:															
Please confirm the scale you are using to express the applicant's visual acuities Snellen <input type="checkbox"/> Snellen expressed as a decimal <input type="checkbox"/> LogMar <input type="checkbox"/>															
i	The visual acuity standard for Group 2 driving is at least 6/7.5 in the better eye and at least 6/60 in the other? (corrective lenses may be worn)	Yes	No												
ii	Do corrective lenses have to be worn to achieve this standard? If yes , glasses <input type="checkbox"/> contact lenses <input type="checkbox"/> both together <input type="checkbox"/>	Yes	No												
	If Glasses are worn for driving, is the corrective power greater than plus (+) 8 dioptries in any meridian of either lens?	Yes	No												
	If correction is worn for driving, is it well tolerated? If NO please give full details in Section 8 .	Yes	No												
iii	Please provide visual acuities of each eye <table border="0" style="width: 100%; text-align: center;"> <tr> <td colspan="2">Uncorrected</td> <td colspan="2">Corrected (if applicable)</td> </tr> <tr> <td>Right</td> <td><input style="width: 50px; height: 30px;" type="text"/></td> <td>Left</td> <td><input style="width: 50px; height: 30px;" type="text"/></td> </tr> <tr> <td>Right</td> <td><input style="width: 50px; height: 30px;" type="text"/></td> <td>Left</td> <td><input style="width: 50px; height: 30px;" type="text"/></td> </tr> </table>	Uncorrected		Corrected (if applicable)		Right	<input style="width: 50px; height: 30px;" type="text"/>	Left	<input style="width: 50px; height: 30px;" type="text"/>	Right	<input style="width: 50px; height: 30px;" type="text"/>	Left	<input style="width: 50px; height: 30px;" type="text"/>		
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iv	Is there a defect in the patient's binocular field of vision (central and/or peripheral)?	Yes	No												
v	Is there diplopia? (a) If yes, is it controlled	Yes	No												
vi	Does the patient on questioning, report symptoms of intolerance to glare and /or impaired contrast sensitivity and/or impaired twilight vision.	Yes	No												
vi	Does the patient have any other ophthalmic condition?	Yes	No												
vi	If YES to questions iv – vii , please give details in Section 8 and enclose any relevant visual field charts or hospital letters.														
2. NERVOUS SYSTEM															
i	Has the patient had any form of epileptic attack? If YES please answer questions a – f below.	YES	NO												
	(a) Has the patient had more than one attack?	Yes	No												
	(b) Please give date of first and last attack:														
	1 st attack	Last attack												
	(c) Is the patient currently on anti-epilepsy medication? If YES please give details of current medication:	Yes	No												
														
	(d) If treated, please give date when treatment ended:														
														

	(c) Diminished / Absent awareness of hypoglycaemia?	Yes	No
v	Has there been any laser treatment for retinopathy? If YES please give date(s) of treatment	Yes	No
vi	Is there a history of hypoglycaemia during waking hours in the last 12 months requiring assistance?	Yes	No
	If YES to any of iv – v above please give details in Section 8 .		

4	PSYCHIATRIC ILLNESS		
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	Is there a history of, or evidence of any of the conditions listed at 1 – 7 below? If NO please go to Section 5 . If YES please answer the following questions and give date(s), prognosis, period of stability and details of medication, dosage and any side effects in Section 8 . (Please enclose relevant notes). (If patient remains under specialist clinic(s) please give details in Section 8).	YES	NO
i	Significant psychiatric disorder within the past 6 months?	Yes	No
ii	A psychotic illness within the past 3 years, including psychotic depression?	Yes	No
iii	Dementia or cognitive impairment?	Yes	No
iv	Persistent alcohol misuse in the past 12 months?	Yes	No
v	Alcohol dependency in the past 3 years?	Yes	No
vi	Persistent drug misuse in the past 12 months?	Yes	No
vi i	Drug dependency in the past 3 years?	Yes	No

5	CARDIAC		
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	Is there a history of, or evidence of, Coronary Artery Disease? If NO please go to Section 5B If YES please answer all questions below and give details at Section 8 of the form and enclose relevant hospital notes.	YES	NO
5 A	CORONARY ARTERY DISEASE		
i	Acute Coronary Syndromes including Myocardial Infarction? If YES please give date(s):	Yes	No
ii	Coronary artery by-pass graft surgery? If YES please give date(s):	Yes	No
iii	Coronary Angioplasty (P.C.I.)? If YES please give date of most recent intervention:	Yes	No
iv	Has the patient suffered from Angina? If YES please give the date of the last attack:	Yes	No

5 B	CARDIA ARRHYTHMIA	
	<p>Is there a history of, or evidence of, cardiac arrhythmia?</p> <p>If NO, go to Section 5C If YES please answer all questions below and give details in Section 8 of the form</p>	YES NO
i	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 last 5 years?	Yes No
ii	Has the arrhythmia been controlled satisfactorily for at least 3 months?	Yes No
iii	Has an ICD or biventricular pacemaker (CRST-D type) been implanted?	Yes No
iv	<p>Has a pacemaker been implanted? If YES:</p> <p>(a) Please supply date: </p> <p>(b) Is the patient free of symptoms that caused the device to be fitted?</p> <p>(c) Does the patient attend a pacemaker clinic regularly?</p>	Yes No Yes No Yes No
5 C	PERIPHERAL ARTERIAL DISEASE (EXCLUDING BUERGER'S DISEASE) AORTIC ANEURYSM/DISSECTION	
	<p>Is there a history or evidence of ANY of the following: If NO go to Section 5D. If YES please answer the questions below and give details in Section 8 of the form.</p>	YES NO
i	Peripheral Arterial Disease (excluding Buerger's Disease)	Yes No
ii	<p>Does the patient have claudication? If YES please give details as to how long in minutes the patient can walk at a brisk pace before being symptom limited</p> <p>..... </p>	Yes No
iii	<p>Aortic Aneurysm If YES:</p> <p>(a) Site of Aneurysm (please tick): Thoracic <input type="checkbox"/> Abdominal <input type="checkbox"/></p> <p>(b) Has it been repaired successfully?</p> <p>(c) Is the transverse diameter currently >5.5 cms? If NO please provide latest measurement: . Date obtained: </p>	Yes No Yes No
iv	<p>Dissection of the Aorta repaired successfully If YES please provide copies of all reports to include those dealing with any surgical treatment.</p>	Yes No

5 D	VALVULAR/CONGENITAL HEART DISEASE		
	Is there a history of, or evidence of, valvular/congenital heart disease? If NO go to Section 5E If YES please answer all questions below and give details in Section 8 of the form	YES	NO
i	Is there a history of congenital heart disorder?	Yes	No
ii	Is there a history of heart valve disease?	Yes	No
iii	Is there any history of embolism? (not pulmonary embolism)	Yes	No
iv	Does the patient currently have significant symptoms?	Yes	No
v	Has there been any progression since the last licence application? (if relevant)	Yes	No
5 E	CARDIAC OTHER		
	Does the patient have a history of ANY of the following conditions: If NO go to Section 5F If YES please answer all questions below and give details in Section 8 of the form	YES	NO
	(a) A history of, or evidence of, heart failure?	Yes	No
	(b) Established cardiomyopathy?	Yes	No
	(c) A heart or heart/lung transplant?	Yes	No
5 F	CARDIAC INVESTIGATIONS (This section must be filled in for all patients) (Please provide relevant reports)		
i	Has a resting ECG been undertaken? If YES does it show:	YES	NO
	(a) Pathological Q waves?	Yes	No
	(b) Left bundle branch block?	Yes	No
	(c) Right bundle branch block?	Yes	No
ii	Has the exercise ECG been undertaken (or planned)? If YES please provide date and give details in Section 8 :	Yes	No
iii	Has an echocardiogram been undertaken (or planned)? (a) If YES please give date and give details in Section 8 :	Yes	No
	(b) If undertaken is/was the left ventricular ejection fraction greater than or equal to 40%?	Yes	No
iv	Has a coronary angiogram been undertaken (or planned)? If YES please provide date and give details in Section 8 :	Yes	No
v	Has a 24 hour ECG tape been undertaken (or planned)?	Yes	No

	If YES please provide date and give details in Section 8 : ..		
vi	Has a Myocardial Perfusion Scan or Stress Echo study been undertaken (or planned)? If YES please provide date and give details in Section 8 :	Yes	No
5 BLOOD PRESSURE (This section must be filled in for all patients)			
5 G			
i	Is today's best systolic pressure reading 180mm Hg or more? (Please give reading) (BP reading:)	Yes	No
ii	Is today's best diastolic pressure reading 100mm Hg or more? (Please give reading) (BP reading:)	Yes	No
iii	Is the patient on anti-hypertensive treatment? If YES to any of the above please provide three previous readings with dates if available: 1. B.P reading: Date: 2. B.P reading: Date: 3. B.P reading: Date:	Yes	No
6. GENERAL (Please answer all questions in this section. If your answer is YES to any question please give full details in Section 8 .)			
i	Is there currently a disability of the spine or limbs likely to impair control of the vehicle?	Yes	No
ii	Is there a history of bronchogenic carcinoma or other malignant tumour, for example, malignant melanoma, with a significant liability to metastasise cerebrally? If YES please give dates and diagnosis and state whether there is current evidence of dissemination?	Yes	No
iii	Is there any evidence the patient has a cancer that causes fatigue or cachexia that affects safe driving?	Yes	No
iv	Is the patient profoundly deaf? If YES is the patient able to communicate in the event of an emergency by speech or by using a device e.g. a textphone?	Yes	No

v	Is there a history of either renal or hepatic failure?	Yes	No
vi	Is there a history of, or evidence of sleep apnoea syndrome? If YES please provide details: (a) Date of diagnosis: (b) Is it controlled successfully? (c) If YES please state treatment: (d) Please state period of control: (e) Please provide neck circumference (f) Please provide girth measurement in cm..... (g) Date last seen by consultant	Yes	No
vi	Does the patient suffer from narcolepsy/cataplexy?	Yes	No
vi i	Is there any other Medical Condition causing daytime sleepiness? If YES please provide details: (a) Diagnosis: (b) Date of diagnosis: (c) Is it controlled successfully? (d) If YES please state treatment: (e) Please state period of control (f) Date last seen by consultant:	Yes	No
vi ii	Does the patient have severe symptomatic respiratory disease causing chronic hypoxia?	Yes	No
ix	Does any medication currently taken cause the patient side effects that could affect safe driving? If YES please provide details:	Yes	No
x	Does the patient have any other medical condition that could affect safe driving? If YES please provide details:	Yes	No

