NORTH TYNESIDE COUNCIL
PUBLIC PROTECTION SERVICES
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North Tyneside Council

MC1

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

Important. This form is only valid for 4 months from the date of examination.

Applicant's details: (please complete using black ink)

Full name: ..... Date of birth: .....

Current address: .....

Email address: ..... Contact Tel: .....

Your doctor's details (only complete if different from examining doctor's details)

G.P.'s Name: .....

Practice address: .....

Email address: ..... Contact Tel: .....

Applicant's consent and declaration: Please read the following carefully before signing and dating the declaration.

I authorise my doctor, specialist or appropriate healthcare professional to disclose medical information and/or reports about my health condition(s), together with any relevant information relevant to fitness to drive, to the Licensing Section, North Tyneside 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 understand that the doctor that I authorise may pass this authorisation to another registered healthcare professional who will be able to provide information about my medical condition that is relevant to my fitness to drive.

I declare that to the best of my knowledge and belief all information given by me to my doctor(s) 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:** .....

Important information for doctors carrying out examinations.

This form must be completed in full, using black ink, 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 hackney carriage (taxi) and private hire drivers meet **Group 2 Standard**, as set out in the DVLA publication '*Assessing fitness to drive – a guide for medical professionals'.* A medical is required on initial application for a licence and then at each five-yearly renewal at age 45, then every year after age 65. Before you fill in this report you must check the applicant's identity and decide if you are able to complete the Vision 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 complete the Vision assessment.

Full name of Examining medical professional: .....

Practice address: .....

Email address: ..... Contact Tel: .....

GMC registration number: .....

Is the applicant a registered patient of the surgery/medical centre at which you practice as a registered medical practitioner? **Yes / No**

Have you reviewed the above applicant's *medical records / electronic medical records? (* Delete as appropriate). **Yes / No**

I can confirm that I have checked the applicant's documents to prove their identity.

Signature of examining doctor: ..... **Date:** .....

VISION ASSESSMENT (To be completed by an optician, optometrist or doctor)

1. Please confirm (✓) the scale you are using to express the applicant's visual acuities. **Please circle**

Snellen ☐ Snellen expressed as a decimal ☐ LogMAR ☐

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.

Right ☐ Left ☐

(b) Are corrective lenses worn for driving? **Yes** **No**

If No, go to Question 3.

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.

Right ☐ Left ☐

(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 dioptres in any meridian of either lens? **Yes** **No**

(e) If correction is worn for driving, is it well tolerated? **Yes** **No**

If No, please give full details in Question 7.

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 in Question 7 below. **Yes** **No**

4. Is there diplopia? **Yes** **No**

(a) Is it controlled? **Yes** **No**

Please indicate below and give full details in Question 7 below.

Patch or glasses with frosted glass ☐ Glasses with/without prism ☐ Other (Please give details) ☐

5. Does the applicant report any symptoms of any of the following that impairs their ability to drive? **Yes** **No**

Please indicate below and give full details in Question 7.

(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? **Yes** **No**

7. Details of additional information: .....

.....

.....

.....

Full name of examining doctor, optician or optometrist undertaking vision assessment:

.....

I confirm that this report was filled in by me at examination and the applicant's history has been taken into consideration.

Signature of examining doctor, optician or optometrist undertaking vision assessment: ..... Date of signature: .....

Please provide your GOC or GMC number. .....

Doctor, optometrist or optician's stamp.

1. NEUROLOGICAL DISORDERS

Please tick (✓) the appropriate boxes. **Please circle**

Is there history or evidence of any neurological disorder? (see conditions in questions 1 to 11 below) **YES NO**
If NO, go to section 2, Diabetes mellitus.
If **YES,** please answer all questions below and enclose relevant hospital notes.

1. Has the applicant had any form of seizure? **Yes No**
- (a) Has the applicant had more than one seizure episode? **Yes No**
- (b) If **Yes**, please give date of first and last episode: First episode ..... Last Episode .....
- (c) Is the applicant currently on anti-epilepsy medication? **Yes No**
  If **Yes**, please fill in the medication section 8, page 8.
- (d) If no longer treated, please give date when treatment ended: .....
- (e) Has the applicant had a brain scan? **Yes No**
  If **Yes**, please give details in section 9, page 8.
- (f) Has the patient had an EEG? **Yes No**

If you have answered **Yes** to any of the above, you must supply medical reports.

2. Has the applicant experienced dissociative /'non-epileptic' seizures? **Yes No**
- (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? **Yes No**

3. Stroke / TIA (*please delete as appropriate*) **Yes No**
If **Yes** please give date of most recent episode: .....
- (a) Has there been a **full** recovery? **Yes No**
- (b) Has a carotid ultrasound been undertaken? **Yes No**
- (c) If **Yes**, was the carotid artery stenosis >50% in either carotid artery?
- (d) Is there a history of multiple strokes/TIA's? **Yes No**

4. Sudden and disabling dizziness/vertigo within the last year with a liability to recur? **Yes No**
5. Subarachnoid haemorrhage (non-traumatic)? **Yes No**
6. Significant head injury within the last 10 years? **Yes No**
7. Any form of brain tumour? **Yes No**
8. Other intracranial pathology? **Yes No**
9. Chronic neurological disorder(s)? **Yes No**
10. Parkinson's disease? **Yes No**
11. Blackout, impaired consciousness or loss of awareness within the last 10 years? **Yes No**

2. DIABETES MELLITUS

Does the patient have diabetes mellitus? **YES NO**
If NO, please go to Section 3, Cardiac.
If **YES**, please answer all questions below.

1. Is the diabetes managed by:
- (a) Insulin? **Yes No**
  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? **Yes No**
  If **No**, please give details in section 9, page 8.
- (c) Other injectable treatments? **Yes No**
- (d) A Sulphonylurea or a Glinide? **Yes No**
- (e) Oral hypoglycaemic agents and diet? **Yes No**
  If **Yes** to any of (a) to (e) please fill in the medication section 8, page 8.
- (f) Diet only? **Yes No**

2.
- (a) Does the applicant test blood glucose at least twice every day? **Yes No**
- (b) 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)? **Yes No**
- (c) Does the applicant keep fast acting carbohydrate within easy reach when driving? **Yes No**
- (d) Does the applicant have a clear understanding of diabetes and the necessary precautions for safe driving? **Yes No**

3. (a) Has the applicant ever had a hypoglycaemic episode? **Yes** **No**
(b) If **Yes**, is there a full awareness of hypoglycaemia? **Yes** **No**

4. Is there a history of hypoglycaemia in the last 12 months requiring the assistance of another person? **Yes** **No**
If **Yes**, please give details and dates below.

.....
.....
.....
.....

5. Is there evidence of:
(a) Loss of visual field? **Yes** **No**
(b) Severe peripheral neuropathy, sufficient to impair limb function for safe driving? **Yes** **No**
If **Yes**, please give details in section 9, page 8.

6. Has there been laser treatment or intra-vitreal treatment for retinopathy? **Yes** **No**
If **Yes**, please give most recent date of treatment: .....

3. CARDIAC

a. Coronary artery disease

Is there a history or evidence of coronary artery disease? **YES** **NO**
If NO, go to section 3b, Cardiac arrhythmia.
If **YES**, please answer all questions below and enclose relevant hospital notes. If there is established coronary heart disease the Authority will require exercise or other functional evaluation at regular intervals not to exceed 3 years.

1. Has the applicant ever had an episode of angina? **Yes** **No**
If **Yes**, please give the date of the last attack: .....

2. Acute coronary syndrome including myocardial infarction? **Yes** **No**
If **Yes**, please give date: .....

3. Coronary angioplasty (PCI)? **Yes** **No**
If **Yes**, please give date of most recent intervention: .....

4. Coronary artery bypass graft surgery? **Yes** **No**
If **Yes**, please give date: .....

5. If **Yes** to any of the above, are there any physical health problems or disabilities (e.g. mobility, arthritis or COPD) that would make the applicant unable to undertake 9 minutes of the standard Bruce Protocol ETT? Please give details:

.....
.....

b. Cardiac arrhythmia

Is there a history or evidence of cardiac arrhythmia? **YES** **NO**
If NO, go to section 3c, Peripheral arterial disease.
If **YES**, please answer all questions below and enclose relevant hospital notes.

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**

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

4. Has a pacemaker or biventricular pacemaker/cardiac resynchronisation therapy pacemaker (CRT-P type) been implanted? **Yes** **No**
If **Yes**:
(a) Please give date of implantation: .....
(b) Is the applicant free of the symptoms that caused the device to be fitted? **Yes** **No**
(c) Does the applicant attend a pacemaker clinic regularly? **Yes** **No**

c. Peripheral arterial disease (excluding Buerger's disease) aortic aneurism/dissection

Is there a history or evidence of peripheral arterial disease (excluding Buerger's disease), aortic aneurysm or dissection? **YES** **NO**
If NO, go to section 3d, Valvular/congenital heart disease.
If **YES**, please answer all questions below and enclose relevant hospital notes.

1. Peripheral arterial disease (excluding Buerger's disease) **Yes** **No**

2. Does the applicant have claudication? **Yes** **No**
If **Yes**, would the applicant be able to undertake 9 minutes of the standard Bruce protocol ETT? **Yes** **No**

3. Aortic aneurysm? **Yes** **No**
If **Yes**:
(a) Site of aneurysm: Thoracic: Abdominal:
(b) Has it been repaired successfully? **Yes** **No**
(c) Please provide latest transverse aortic diameter measurement and date obtained:

.... **cm.** Date: .....

4. Dissection of the aorta repaired successfully? **Yes** **No**
If **Yes**, please provide copies of all reports including those dealing with any surgical treatment.

5. Is there a history of Marfan's disease? **Yes** **No**
If **Yes**, please provide relevant hospital notes.

d. Valvular/congenital heart disease

Is there a history or evidence of valvular or congenital heart disease? **YES** **NO**
If NO, go to section 3e, Cardiac other.
If **YES**, answer all questions below and provide relevant hospital notes.

1. Is there a history of congenital heart disease? **Yes** **No**

2. Is there a history of heart valve disease? **Yes** **No**

3. Is there a history of aortic stenosis? **Yes** **No**
If **Yes**, please provide relevant reports (including echocardiogram).

4. Is there a history of embolic stroke? **Yes** **No**

5. Does the applicant currently have significant symptoms? **Yes** **No**

6. Has there been any progression (either clinically or on scans etc) since the last licence application? **Yes** **No**

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 8.

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 8 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 **100 mm/Hg diastolic** or more, please take a further 2 readings at least 5 minutes apart and record the best of the 3 readings below.

1. Please record today's best resting blood pressure reading: ..... Hg systolic **/** ..... Hg diastolic

2. Is the applicant on anti-hypertensive treatment? **Yes** **No**
If **Yes**, please provide three previous readings with dates if available.

..... Hg systolic **/** ..... Hg diastolic Date: .....

..... Hg systolic **/** ..... Hg diastolic Date: .....

..... Hg systolic **/** ..... Hg diastolic Date: .....

3. Is there a history of malignant hypertension? **Yes** **No**
If **Yes**, please give details in section 9, page 8 (including date of diagnosis and any treatment etc).

h. Cardiac investigations

Have any cardiac investigations been undertaken or planned? **YES** **NO**
If NO, please go to section 4, Psychiatric illness
If **YES**, please answer questions 1 to 7.

1. Is there a history of the following:
(a) Left bundle branch block (LBBB)? **Yes** **No**
(b) Right bundle branch block (RBBB)? **Yes** **No**
If **Yes** to either (a) or (b), please provide relevant report(s) or comment in section 9, page 8.

Note: If Yes to questions 2 to 6 please give dates, give details in section 9, page 8 and provide relevant reports.

2. Has an exercise ECG been undertaken (or planned)? Date: ..... **Yes** **No**

3. Has an echocardiogram been undertaken (or planned)? Date: ..... **Yes** **No**
(a) If undertaken, is or was the left ejection fraction greater than or equal to 40%? **Yes** **No**

4. Has a coronary angiogram been undertaken (or planned)? Date: ..... **Yes** **No**

5. Has a 24 hour ECG tape been undertaken (or planned)? Date: ..... **Yes** **No**

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

7. Has a myocardial perfusion scan, stress echo study or cardiac MRI been undertaken (or planned)? Date: ..... **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? **Yes** **No**
If **Yes**, please confirm condition: .....

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 any concerns which have resulted in ongoing investigations for such possible diagnoses? **Yes** **No**

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? **Yes** **No**
(b) Has the applicant undergone an alcohol detoxification programme? **Yes** **No**
If **Yes**, give date started: .....

2. Persistent alcohol misuse in the past 3 years? **Yes** **No**
(a) Is it controlled? **Yes** **No**

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(s) misused? .....
(b) Is it controlled? **Yes** **No**
(c) Has the applicant undertaken an opiate treatment programme? **Yes** **No**
If **Yes**, give date started: .....

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

2. If another measurement other than AHI is used, it must be one that is recognised in clinical practice as equivalent to AHI. The Council does not prescribe different measurements as this is a clinical issue. Please give details in Section 9, page 8, Further details.

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

(i) Date of diagnosis: .....
(ii) Is it controlled successfully? **Yes** **No**
(iii) If **Yes**, please state treatment: .....
(iv) Is the 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 8.

7. Is there a history of renal failure? **Yes** **No**
If **Yes**, please give details in section 9, page 8.

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 8.

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

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): .....

Medication: ..... Dosage: .....
Reason for taking: .....
Approximate date started (if known): .....

Medication: ..... Dosage: .....
Reason for taking: .....
Approximate date started (if known): .....

Medication: ..... Dosage: .....
Reason for taking: .....
Approximate date started (if known): .....

9. FURTHER DETAILS

Please send us copies of relevant hospital notes. Do not send any notes not related to fitness to drive. Use the space below to provide any additional information.

10. CONSULTANTS' DETAILS

Please provide details of type of specialists or consultants, including address. (If more consultants seen give details on a separate sheet).

Name: ..... Consultant in: .....
Address: .....
Reason for attendance: ..... Date of last appointment: .....

Name: ..... Consultant in: .....
Address: .....
Reason for attendance: ..... Date of last appointment: .....

Name: ..... Consultant in: .....
Address: .....
Reason for attendance: ..... Date of last appointment: .....

11. EXAMINING DOCTOR'S DECLARATION:

Please read the following carefully before completing, signing and dating the declaration. If the applicant is not a registered patient with your practice or you have not reviewed his/her medical records then do not complete the declaration.

I confirm that I am currently GMC registered and licensed to practise in the UK.

I confirm that I have reviewed the applicant's *medical records / electronic medical records and that in my opinion nothing therein contradicts or tends to contradict the information given to me by the applicant.
(* delete as appropriate).

I confirm that this report was filled in by me at examination and I have taken the applicant's history into account for the purpose of assessing their fitness to act as a driver of a Hackney Carriage (taxi) or Private Hire vehicle under the DVLA Group 2 medical standards applied by DVLA in the current version of "*Assessing fitness to drive – a guide for medical professionals*".

I certify that having regard to the foregoing, the applicant * <u>MEETS / DOES NOT MEET</u> (*delete as appropriate) the minimum standards required for the DVLA Group 2 medical standard.

Signature of examining doctor: ..... Date of signature: .....

Doctor's stamp

Applicant's full name: ..... **Date of Birth**: .....