STROUD DISTRICT COUNCIL
www.stroud.gov.uk

Group 2 Medical Examination Report for a Taxi and/or Private Hire Driver Licence

This medical form is based on the DVLA D4 medical examination form for a Group 2 (HCV or PHV) licence. The medical must be completed by:

- The applicant's own general practitioner or,
- A suitably qualified medical practitioner that has been provided with a Summary Medical Record obtained by the driver from their own General Practitioner. The Summary Medical Record should be no more than two months old at the time that it is provided to the medical practitioner undertaking the medical.

The doctor completing the medical examination should take account of the Group 2 standards contained in the DVLA's guidance document 'Assessing fitness to drive'. This is available on the DVLA's website https://www.gov.uk/guidance/assessing-fitness-to-drive-a-guide-for-medical-professionals

The examination includes a vision assessment. If the doctor is unable to fully answer the vision assessment questions the applicant must have this part of the medical completed by an optician or optometrist.

At the end of the form, on page 8, the doctor will state whether or not the applicant is fit to drive a hackney carriage and/or private hire vehicle

Information for the applicant about the medical standards to pass a Group 2 medical can be found in the DVLA's leaflet INF4D. A link to this leaflet is available on the DVLA's website https://www.gov.uk/government/publications/d4-medical-examiner-report-for-a-lorry-or-bus-driving-licence

Applicants Name _____

Date of Birth _____

Driver & Vehicle Licensing Agency

Medical examination report

Vision assessment

To be filled in by a doctor or optician/optometrist

D4

If correction is needed to meet the eyesight standard for driving, ALL questions must be answered. If correction is NOT needed, questions 5 and 6 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.
   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.

Uncorrected		Corrected (using prescription worn for driving)	
R	L	R	L

3. Is the visual acuity at least 6/7.5 in the better eye and at least 6/60 in the other eye (corrective lenses may be worn to meet this standard)? YES ☐ NO ☐

4. Were corrective lenses worn to meet this standard? YES ☐ NO ☐
   If **YES**, glasses ☐ contact lenses ☐ both together ☐

5. If **glasses** (not contact lenses) are worn for driving, is the corrective power greater than plus (+)8 dioptres in any meridian of either lens? YES ☐ NO ☐

6. If correction is worn for driving, is it well tolerated? YES ☐ NO ☐
   If **NO**, please give full details in the box provided

If you answer yes to any of the following give details in the box provided.

7. Is there a history of any medical condition that may affect the applicant's binocular field of vision (central and/or peripheral)? YES ☐ NO ☐
   If formal visual field testing is considered necessary, DVLA will commission this at a later date

8. Is there diplopia? YES ☐ NO ☐
   (a) If **YES**, is it controlled? ☐ ☐
   If **YES**, please give full details in the box provided

9. Does the applicant on questioning, report symptoms of intolerance to glare and/or impaired contrast sensitivity and/or impaired twilight vision? YES ☐ NO ☐

10. Does the applicant have any other ophthalmic condition? YES ☐ NO ☐
    If **YES**, please give full details in the box provided

Details/additional information

You must sign and date this section.

Name of examining doctor/optician (print)

Signature of examining doctor/optician

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

Driver & Vehicle Licensing Agency

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.

D4

1 Nervous system

Please tick ✓ the appropriate box(es)

	YES	NO
Is there a history of, or evidence of **any** neurological disorder?	☐	☐

If **NO**, go to section **2**
If **YES**, please answer **ALL** questions below

	YES	NO
1. Has the applicant had any form of seizure?	☐	☐
(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, page 7**		
(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, page 6**		
(f) Has the applicant had an EEG?	☐	☐
If **YES** to any of above, please supply reports if available.		

Is there **ANY** history of the following:	YES	NO
2. 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?	☐	☐
3. Sudden and disabling dizziness/vertigo within the last year with a liability to recur?	☐	☐
4. Subarachnoid haemorrhage?	☐	☐
5. Serious traumatic brain injury within the last 10 years?	☐	☐
6. Any form of brain tumour?	☐	☐
7. Other brain surgery or abnormality?	☐	☐
8. Chronic neurological disorders?	☐	☐
9. Parkinson's disease?	☐	☐
10. 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, page 6**		
11. Does the applicant suffer from narcolepsy?	☐	☐
If **YES, please give date(s) and details in section 6, page 6**		

2 Diabetes mellitus

	YES	NO
Does the applicant have diabetes mellitus?	☐	☐

If **NO**, go to section 3, page 4
If **YES**, please answer ALL the following questions.

	YES	NO
1. Is the diabetes managed by:		
(a) Insulin?	☐	☐
If **YES**, 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**, please give details in **section 6, page 6**		
(c) Other injectable treatments?	☐	☐
(d) A Sulphonylurea or a Glinide?	☐	☐
(e) Oral hypoglycaemic agents and diet?	☐	☐
If **YES** to any of a-e, please fill in current medication in **section 8, page 7**		
(f) Diet only?	☐	☐
2. (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?	☐	☐
3. Is there any evidence of impaired awareness of hypoglycaemia?	☐	☐
4. Is there a history of hypoglycaemia in the last 12 months requiring the assistance of another person?	☐	☐
5. 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, page 6**		
6. 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

3 Psychiatric illness

Is there a history of, or evidence of, psychiatric illness, drug/alcohol misuse within the last 3 years? YES ☐ NO ☐

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

If **YES**, please answer ALL questions below

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

If 'YES' to any questions above, please provide full details in section 6, page 6, including dates, period of stability and where appropriate consumption and frequency of use.

4 Cardiac

a 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? YES ☐ NO ☐
   If **YES**, please give the date of the last known attack D D M M Y Y
2. Acute coronary syndrome including myocardial infarction? YES ☐ NO ☐
   If **YES**, please give date D D M M Y Y
3. Coronary angioplasty (P.C.I.)? YES ☐ NO ☐
   If **YES**, please give date of most recent intervention D D M M Y Y
4. Coronary artery by-pass graft surgery? YES ☐ NO ☐
   If **YES**, please give date D D M M Y Y

b 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, page 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 YES ☐ NO ☐
2. Has the arrhythmia been controlled satisfactorily for at least 3 months? YES ☐ NO ☐
3. Has an ICD or biventricular pacemaker (CRT-D type) been implanted? YES ☐ NO ☐
4. Has a pacemaker been implanted? YES ☐ NO ☐
   If **YES:**
   (a) Please supply date of implantation D D M M Y Y
   (b) Is the applicant free of the symptoms that caused the device to be fitted? ☐ ☐
   (c) Does the applicant attend a pacemaker clinic regularly? ☐ ☐

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

Is there a history of, or evidence of, peripheral arterial disease (excluding Buerger's disease), aortic aneurysm/dissection? YES ☐ NO ☐

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

If **YES**, please answer ALL questions below and give details in **section 6 page 6,** enclosing relevant hospital notes.

1. Peripheral arterial disease (excluding Buerger's disease) YES ☐ NO ☐
2. Does the applicant have claudication? YES ☐ NO ☐
   If **YES**, how long in minutes can the applicant walk at a brisk pace before being symptom-limited?
   Please give details
3. Aortic aneurysm? YES ☐ NO ☐
   If **YES:**
   (a) Site of Aneurysm: Thoracic ☐ Abdominal ☐
   (b) Has it been repaired successfully? ☐ ☐
   (c) Is the transverse diameter **currently** > 5.5 cm? ☐ ☐
   If **NO**, please provide latest measurement and date obtained
   D D M M Y Y
4. Dissection of the aorta repaired successfully? YES ☐ NO ☐
   If **YES**, please provide copies of all reports to include those dealing with any surgical treatment.
5. Is there a history of Marfan's disease? YES ☐ NO ☐
   If **YES**, please provide relevant hospital notes

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

d 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 page 6.**

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
4. Is there any history of embolism? (**not** pulmonary embolism) YES ☐ NO ☐
5. Does the applicant currently have significant symptoms? YES ☐ NO ☐
6. Has there been any progression since the last licence application? (if relevant) YES ☐ NO ☐

e Cardiac other

Is there a history of, or evidence of heart failure? YES ☐ NO ☐

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

If **YES,** please answer ALL questions below

1. Established cardiomyopathy? YES ☐ NO ☐
2. Has a left ventricular assist device (LVAD) been implanted? YES ☐ NO ☐
3. A heart or heart/lung transplant? YES ☐ NO ☐
4. Untreated atrial myxoma? YES ☐ NO ☐

f Cardiac investigations

Have any cardiac investigations been undertaken or planned? YES ☐ NO ☐

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

If **YES,** please answer ALL questions

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 provide a copy of the relevant ECG report or comment at **section 6, page 6.***
2. Has an exercise ECG been undertaken (or planned)? YES ☐ NO ☐
   If **YES**, please give date and give details in **section 6, page 6**
   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, page 6.**
   (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)? YES ☐ NO ☐
   If **YES**, please give date and give details in **section 6, page 6.**
   Please provide relevant reports if available
5. Has a 24 hour ECG tape been undertaken (or planned)? YES ☐ NO ☐
   If **YES**, please give date and give details in **section 6, page 6.**
   Please provide relevant reports if available
6. Has a myocardial perfusion scan or stress echo study been undertaken (or planned)? YES ☐ NO ☐
   If **YES**, please give date and give details in **section 6, page 6.**
   Please provide relevant reports if available

g Blood pressure

If blood pressure is 180/100mm Hg systolic or more and/or 100mm Hg diastolic or more, please take a further 2 readings at least 5 minutes apart and record the best of the 3 readings in the box provided.

1. Please record today's **best** blood pressure reading
2. Is the applicant on anti-hypertensive treatment? YES ☐ NO ☐
   If **YES**, please provide three previous readings with dates if available

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

5 General

All questions MUST be answered

If **YES** to any, give full details in section 6,

1. Is there **currently** any functional impairment that is likely to affect control of the vehicle? YES ☐ NO ☐

2. Is there a history of bronchogenic carcinoma or other malignant tumour with a significant liability to metastasise cerebrally? YES ☐ NO ☐

3. Is there any illness that may cause significant fatigue or cachexia that affects safe driving? YES ☐ NO ☐

4. 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? ☐ ☐

5. Does the applicant have a history of liver disease of any origin? YES ☐ NO ☐

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

6. Is there a history of renal failure? YES ☐ NO ☐

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

7. Is there a history of, or evidence of, obstructive sleep apnoea syndrome or any other medical condition causing excessive sleepiness? YES ☐ NO ☐

   If **YES**, please give diagnosis

   a) If Obstructive Sleep Apnoea Syndrome, please indicate the severity

   Mild (AHI <15) ☐

   Moderate (AHI 15 - 29) ☐

   Severe (AHI >29) ☐

   Not known ☐

   If another measurement other than AHI is used, it must be one that is recognised in clinical practice as equivalent to AHI. DVLA does not prescribe different measurements as this is a clincal issue. Please give details in section 6.

   b) Please answer questions i – vi for ALL sleep conditions

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

   (ii) Is it controlled successfully? YES ☐ NO ☐

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

   (iv) Is applicant compliant with treatment? YES ☐ NO ☐

   (v) Please state period of control

   (vi) Date of last review D D M M Y Y

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 provide details of medication and symptoms in **section 6**

10. Does the applicant have an ophthalmic condition? YES ☐ NO ☐

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

11. Does the applicant have any other medical condition that could affect safe driving? YES ☐ NO ☐

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

6 Further details

Please forward 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

Medical Practitioner Details

To be completed by the doctor carrying out the examination

Doctor's Details **Surgery Stamp**

Name _____

Address _____

_____

Telephone number _____

Email address _____

Statement by Medical Practitioner

To be completed by the Doctor carrying out the examination

1. I confirm that I am the applicant's GP and have access to the applicant's medical records ☐ ✓

   Or

   I confirm that I am a suitably qualified medical practitioner that has been provided with a Summary Medical Record obtained by the applicant from the applicant's own GP and that the Summary Medical Record is no more than two months old at the time of this medical ☐

2. I certify that, having regard to the DVLA's guidance*, the applicant:

	✓	Doctors Initials
Meets the group 2 guideline on fitness to drive	☐	_____
Does not meet the group 2 guideline on fitness to drive	☐	_____

3. Stroud District Council licensed taxi and private hire drivers must provide a medical every 3 years and every year after the age of 65. If you consider that a further medical examination is required before the timescales above please state in what period of time a further medical examination is necessary. _____

4. Any other comments _____

   _____

Signature (of Doctor) _____

Date _____

*The DVLA's guidance on assessing fitness to drive is available on their website: https://www.gov.uk/guidance/assessing-fitness-to-drive-a-guide-for-medical-professionals

Applicant Details

To be completed by the applicant in the presence of the medical practitioner carrying out the examination

Your details

Your name _____

Your home address _____

Date of birth _____

Your doctor's details (if different to the doctor carrying out the examination)

Name of your doctor or practice _____

Address of doctor or practice _____

Phone number of doctor or practice _____

Email address of doctor or practice _____

Your consultant/specialist details (if applicable)

Name of your consultant/specialist _____

Address _____

Phone number _____

Email address _____

Date last seen _____

Authorisation and Declaration of Applicant

To be completed by the applicant in the presence of the medical examiner

- I give consent to the doctor(s) and specialist(s) to release reports/medical information about any conditions relevant to my fitness to drive to Stroud District Council in conjunction with my application and during the period that a licence is in force
- I understand that Stroud District Council may require me to undergo further medical tests at my expense, now or at any point in the future, if a licence is granted, in order to establish my fitness to drive
- I declare that I have checked the details I have given in this report and that, to the best of my knowledge and belief, they are correct

Signature of Applicant _____

Date _____