

# **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 (lorry or bus) licence. The medical must be completed by the applicant's own general practitioner or by a medical practitioner that has access to the applicant's medical records.

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** \_\_\_\_\_



# Medical examination report

## Vision assessment

To be filled in by a doctor or optician/optometrist



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.

- Please confirm (✓) the scale you are using to express the driver's visual acuities.  
 Snellen  Snellen expressed as a decimal   
 LogMAR
- 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 <small>(using prescription worn for driving)</small>	
R	L	R	L
- 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**
- Were corrective lenses worn to meet this standard? **YES NO**  
   
 If **YES**, glasses  contact lenses  both together
- 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**
- 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.**
- 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**
- Is there diplopia? **YES NO**  
   
 (a) If **YES**, is it controlled?    
 If **YES**, please give full details in the box provided
- Does the applicant on questioning, report symptoms of intolerance to glare and/or impaired contrast sensitivity and/or impaired twilight vision? **YES NO**
- 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
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Please provide your GOC, HPC or GMC number

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Doctor/optometrist/optician's stamp

Applicant's full name

Date of birth

D	D	M	M	Y	Y
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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.



### 1 Nervous system

Please tick ✓ the appropriate box(es)

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

If **NO**, go to section 2

If **YES**, please answer **ALL** questions below **YES NO**

- Has the applicant had any form of seizure?  
  - Has the applicant had more than one attack?
  - Please give date of first and last attack  
First attack          
Last attack
- Is the applicant currently on anti-epileptic medication?    
If **YES**, please fill in current medication in **section 8, page 7**
- If no longer treated, please give date when treatment ended
- Has the applicant had a brain scan?    
If **YES**, please give details in **section 6, page 6**
- 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**

- Stroke or TIA?    
If **YES**, please give date          
Has there been a **FULL** recovery?    
Has a carotid ultra sound been undertaken?
- Sudden and disabling dizziness/vertigo within the last year with a liability to recur?
- Subarachnoid haemorrhage?
- Serious traumatic brain injury within the last 10 years?
- Any form of brain tumour?
- Other brain surgery or abnormality?
- Chronic neurological disorders?
- Parkinson's disease?
- 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**
- Does the applicant suffer from narcolepsy?    
If **YES**, please give date(s) and details in **section 6, page 6**

### 2 Diabetes mellitus

Does the applicant have diabetes mellitus? **YES NO**

If **NO**, go to section 3, page 4

If **YES**, please answer **ALL** the following questions.

- Is the diabetes managed by: **YES NO**
  - Insulin?    
If **YES**, please give date started on insulin
  - 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**
  - Other injectable treatments?
  - A Sulphonylurea or a Glinide?
  - Oral hypoglycaemic agents and diet?    
If **YES** to any of a-e, please fill in current medication in **section 8, page 7**
  - Diet only?
- Does the applicant test blood glucose at least twice every day? **YES NO**
  - Does the applicant test at times relevant to driving?
  - Does the applicant keep fast acting carbohydrate within easy reach when driving?
  - Does the applicant have a clear understanding of diabetes and the necessary precautions for safe driving?
- Is there any evidence of impaired awareness of hypoglycaemia? **YES NO**
- Is there a history of hypoglycaemia in the last 12 months requiring the assistance of another person? **YES NO**
- Is there evidence of: **YES NO**
  - Loss of visual field?
  - 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**
- Has there been laser treatment or intra-vitreal treatment for retinopathy? **YES NO**    
If **YES**, please give date(s) of treatment.

Applicant's full name

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### 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
2. Acute coronary syndrome including myocardial infarction?  YES  NO  
If **YES**, please give date
3. Coronary angioplasty (P.C.I.)?  YES  NO  
If **YES**, please give date of most recent intervention
4. Coronary artery by-pass graft surgery?  YES  NO  
If **YES**, please give date

### 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
  - (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

#### 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?  YES  NO
  - (c) Is the transverse diameter currently > 5.5 cm?  YES  NO  
If **NO**, please provide latest measurement and date obtained
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

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**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**. **YES NO**

1. Is there a history of congenital heart disease?
2. Is there a history of heart valve disease?
3. Is there a history of aortic stenosis?    
 If **YES**, please provide relevant reports
4. Is there any history of embolism? (not pulmonary embolism)
5. Does the applicant currently have significant symptoms?
6. Has there been any progression since the last licence application? (if relevant)

**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 **YES NO**

1. Established cardiomyopathy?
2. Has a left ventricular assist device (LVAD) been implanted?
3. A heart or heart/lung transplant?
4. Untreated atrial myxoma?

**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 **YES NO**

1. Has a resting ECG been undertaken?    
 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

**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 clinical issue. Please give details in section 6.*

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

- (i) Date of diagnosis       YES NO
- (ii) Is it controlled successfully?
- (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

- 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**

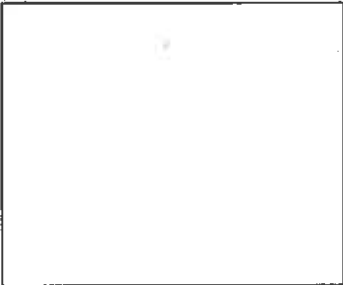
Please forward copies of relevant hospital notes. **PLEASE DO NOT** send any notes not related to fitness to drive.

Applicant's full name

Date of birth

# 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 have access to the applicant's medical records

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

Meets the group 2 guideline on fitness to drive

Does not meet the group 2 guideline on fitness to drive

Doctors Initials

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 my 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 \_\_\_\_\_