Driver & Vehicle Licensing Agency

Medical examination report for a Group 2 (lorry or bus) licence

D4

If this form is not fully completed we will return it to you and your application will be delayed.

For information about completing the form read the leaflet INF4D.
This is also available at **www.gov.uk/reapply-driving-licence-medical-condition**

Your details (applicant)

Name _____

Full address _____

Daytime phone number _____ Date of birth _____

Email address _____

Date first licensed to drive a lorry (if known) _____ Date first licensed to drive a bus (if known) _____

Your doctor's details

Doctor's name _____

Full address _____

Phone number _____ Email address _____

You must sign and date the declaration on page 8 when the doctor and/or optician has completed the report.

This report is valid for 4 months from the date the doctor and/or optician or optometrist signs it. Please return it together with your application form.

Examining doctor's details – to be completed by the doctor carrying out the examination.

Doctor's name Dr

Full address JUST HEALTH CLINIC

Phone number 01282 936900 Email address info@justhealth.co.uk

GMC registration number | | | | | | | | | | |

You must sign and date this form in Section 10. All black outlined boxes MUST be answered. Please make sure all sections of the form have been completed. The form will be returned to you if you don't do this.

CUSTOMER SERVICE EXCELLENCE CSE

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 (see INF4D).

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

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 that impairs their ability to drive? **Yes** ☐ **No** ☐

10. Does the applicant have any other ophthalmic condition? **Yes** ☐ **No** ☐

If **Yes** to any of questions 7-10, 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 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 and take the applicant's history.

D4

1 Neurological disorders

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** the questions below, give details in section 6, page 6 and enclose relevant hospital notes.

		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.		
2.	Stroke or TIA?	☐	☐
	If **Yes,** please give date D D M M Y Y		
	Has there been a **FULL** recovery?	☐	☐
	Has a carotid ultrasound been undertaken?	☐	☐
	If **Yes**, was the carotid artery stenosis >50% in either carotid artery?	☐	☐
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?	☐	☐
11.	Does the applicant suffer from narcolepsy?	☐	☐

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 questions below.

		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 continuous 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 **(no more than 2 hours before the start of the first journey and every 2 hours while 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?	☐	☐
	If **Yes**, please give dates and details in **section 6**		
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 4-5 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 Cardiac

a Coronary artery disease

Is there a history of, or evidence of, coronary artery disease? **Yes** ☐ **No** ☐

If **No,** go to **section 3b**

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 (PCI)? **Yes** ☐ **No** ☐

If **Yes**, please give date of most recent intervention D D M M Y Y

4. Coronary artery bypass graft surgery? **Yes** ☐ **No** ☐

If **Yes**, please give date D D M M Y Y

5. If **Yes** to any of the above, are there any physical health problems (e.g. mobility/arthritis, COPD) that would make the applicant unable to undertake 9 minutes of the standard Bruce Protocol ETT? **Yes** ☐ **No** ☐

b Cardiac arrhythmia

Is there a history of, or evidence of, cardiac arrhythmia? **Yes** ☐ **No** ☐

If **No**, go to **section 3c**

If **Yes**, please answer **all** questions below and give details in **section 6, page 6** and enclose relevant hospital notes.

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 give 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 3d**

If **Yes**, please answer **all** questions below and give details in **section 6 page 6,** 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**, 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

d Valvular/congenital heart disease

Is there a history of, or evidence of, valvular/congenital heart disease? **Yes** ☐ **No** ☐

If **No**, go to **section 3e**

If **Yes**, please answer **all** questions below and give details in **section 6 page 6** and enclose 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

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** ☐

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

e Cardiac other

Is there a history of, or evidence of heart failure? Yes ☐ No ☐

If **No,** go to **section 3f**

If **Yes,** please answer **all** questions and enclose relevant hospital notes.

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 channelopathies

Is there a history of, or evidence of either of the following conditions? Yes ☐ No ☐

If **No**, go to **section 3g**

1. Brugada syndrome? Yes ☐ No ☐
2. Long QT syndrome? Yes ☐ No ☐

   If **Yes** to either, please give details in section 6 and enclose relevant hospital notes.

g Blood pressure

If resting blood pressure is 180 mm/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 resting** blood pressure reading ☐

2. Is the applicant on anti-hypertensive treatment? Yes ☐ No ☐

   If **Yes**, please provide three previous readings with dates if available

   ☐ D D M M Y Y

   ☐ D D M M Y Y

   ☐ D D M M Y Y

3. Is there a history of malignant hypertension? Yes ☐ No ☐

   If **Yes**, please provide details in section 6 (including date of diagnosis and any treatment etc)

h Cardiac investigations

Have any cardiac investigations been undertaken or planned? Yes ☐ No ☐

If **No,** go to **section 4**

If **Yes,** please answer questions 1-6

1. Has a resting ECG been undertaken? Yes ☐ No ☐

   If **Yes**, does it show:

   (a) pathological Q waves? Yes ☐ No ☐

   (b) left bundle branch block? Yes ☐ No ☐

   (c) right bundle branch block? Yes ☐ No ☐

   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 D D M M Y Y 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 D D M M Y Y and give details in **section 6, page 6**.

   (b) If undertaken, is/was the left ejection fraction greater than or equal to 40%? Yes ☐ No ☐

   Please provide relevant reports if available

4. Has a coronary angiogram been undertaken (or planned)? Yes ☐ No ☐

   If **Yes**, please give date D D M M Y Y 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 D D M M Y Y 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 D D M M Y Y and give details in **section 6, page 6**.

   Please provide relevant reports if available

4 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 5**

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.

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 and enclose relevant hospital notes.

1. 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 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

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? ☐ ☐

6. Does the applicant have a history of liver disease of any origin? **Yes** ☐ **No** ☐

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

7. Is there a history of renal failure? **Yes** ☐ **No** ☐

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

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 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

7 Consultants' details

Details of type of specialist(s)/consultants, including address.

Consultant in
Name
Address

Date of last appointment D D M M Y Y

Consultant in
Name
Address

Date of last appointment D D M M Y Y

Consultant in
Name
Address

Date of last appointment D D M M Y Y

8 Medication

Please provide details of all current medication (continue on a separate sheet if necessary)

Medication	Dosage
Reason for taking:	

Medication	Dosage
Reason for taking:	

Medication	Dosage
Reason for taking:	

Medication	Dosage
Reason for taking:	

Medication	Dosage
Reason for taking:	

9 Additional information

Patient's weight (kg)	
Height (cms)	
Details of smoking habits, if any	
Number of alcohol units taken each week	

10 Examining doctor's signature and stamp

To be completed by the doctor carrying out the examination.

Please ensure all sections of the form have been completed. The form will be returned to you if you don't do this.

I confirm that this report was completed by me at examination. I also confirm that I am currently GMC registered and licensed to practice in the UK or I am a doctor who is medically registered within the EU, if the report was completed outside of the UK.

Signature of practitioner

Date of signature D D M M Y Y

Doctor's stamp

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

The applicant must complete this page

Applicant's declaration

You **must** fill in this section and **must not** alter it in any way.
Please read the following important information carefully then sign to confirm the statements below.

Important information about fitness to drive

As part of the investigation into your fitness to drive, we (DVLA) may require you to have a medical examination or some form of practical assessment. If we do, the people involved will need your medical details to carry out an appropriate assessment. These may include doctors, orthoptists at eye clinics or paramedical staff at a driving assessment centre. We will only release information relevant to the medical assessment of your fitness to drive. Also, where the circumstances of your case appear exceptional, the relevant medical information would need to be considered by one or more members of the Secretary of State's Honorary Medical Advisory Panels. Panel members must adhere strictly to the principle of confidentiality.

Declaration

I authorise my doctor and specialist to release reports and information about my condition which is relevant to my fitness to drive, to the Secretary of State's medical adviser.

I understand that the Secretary of State may disclose relevant medical information that is necessary to investigate my fitness to drive, to doctors, paramedical staff and panel members.

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

I understand that it is a criminal offence if I make a false declaration to obtain a driving licence and can lead to prosecution.

Name _____

Signature _____

Date _____

I authorise the Secretary of State to:	**Yes**	**No**
inform my doctors about the outcome of my case	☐	☐
release reports to my doctors	☐	☐

Checklist	**Yes**
■ Have you signed and dated the declaration?	☐
■ Have you checked that the optician or doctor has filled in all parts of the report and all relevant hospital notes have been enclosed?	☐

This report is valid for 4 months from the date the doctor, optician or optometrist signs it.
Please return it together with your application form.