Liverpool City Council

JULY 2019

MEDICAL ASSESSMENT

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

Notes for the Applicant

This medical assessment must be carried out by a General Practitioner in the medical practice to which you are registered or by a GP or Doctor who has access to your medical records which must be reviewed prior to completion of this assessment.

The vision assessment must be completed by a doctor or optician/optometrist. Some doctors will be able to fill in both vision and medical assessment section of the report. If your doctor is unable to fully answer all of the questions on the vision assessment you must have it completed by an optician/optometrist.

IMPORTANT: ASSESSMENTS MUST NOT TAKE PLACE MORE THAN TWO CALENDAR MONTHS BEFORE THE DATE A LICENCE IS GRANTED OR RENEWED.

Applicant's Details: (to be completed in the presence of the GP or Doctor carrying out the examination)

Full name: …….. Date of Birth: …… Age: …….

Address:

Post Code:

Contact telephone number: Email:

Privacy Policy

Here at Liverpool City Council we take your privacy seriously. We will only use your personal information to administer your application and provide the products and services you have requested from us.

From time to time we may need to contact you with details of the service or information we require from you and we will do this using the contact information you provided on your application form. This can either be by post, email, telephone or text message.

The Council has a duty to protect the public and we implement a number of security measures to maintain the safety of your personal information. Please be aware however that the information you provide on this application may be shared with other public bodies where required, such as Council Departments and Government Services, which may be used for the prevention of fraud or other serious offences.

If you require a copy of the data we hold or believe it to be inaccurate please contact the Council's Data Protection Officer by filling in a request form at https://liverpool.gov.uk/contact-us/data-protection-enquiry/

Any further information held by the Council about individuals will be held securely and in compliance with the law. Information will not be held for longer than required and will be disposed of securely. Further information regarding retention periods is available on the Council's website at https://liverpool.gov.uk/privacy-notice/what-we-do-with-your-data/

GP or Doctor Signature _____ Date _____

Applicant's consent and declaration

I authorise my General Practitioner(s) or Doctor to provide the information requested on this form relevant to my fitness to drive a licensed hackney carriage or private hire vehicle to Liverpool City Council in order to assess my fitness to hold a hackney carriage or private hire driver licence.

I declare that to the best of my knowledge and belief all information given by me to my GP or Doctor in connection with this examination is true.

Signed:	Date:

General Practitioner/Doctor

This form must be completed in full by the <u>applicant's own GP or Doctor or a GP or Doctor who has reviewed the applicant's medical records.</u> Please answer all questions and once completed sign the declaration at the end.

Liverpool City Council's policy on medical fitness requires that hackney carriage and private hire drivers meet Group 2 Medical Standards, as set out in the DVLA publication '*Assessing fitness to drive - a guide for medical professionals'*.

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 hackney carriage and private hire drivers.

(a)	Is the applicant a registered patient of the surgery / medical centre at which you practice as a registered medical practitioner?	YES	NO
(b)	Have you reviewed the above applicant's medical records? If reviewing a printout of the medical records please give date of printout:	YES	NO

GP or Doctor Signature _____ Date _____

Section 1

Vision Assessment – to be completed by the GP or Optician/Optometrist

Please see the current DVLA guidance so that you can decide whether you are able to fully complete the vision assessment at www.gov.uk/current-medical-guidelines-dvla-guidance-for-professionals

1	Please confirm the scale you are using to express the driver's visual acuities: ☐ Snellen ☐ Snellen expressed as a decimal ☐ LogMAR		
		YES	**NO**
2	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)	☐	☐
3	Were corrective lenses worn to meet this standard? If **Yes** please indicate if: ☐ Glasses ☐ Contact lenses ☐ Both	☐	☐

4	**Uncorrected**		**Corrected (using the prescription worn for driving)**	
	Right	Left	Right	Left

5	If **glasses** (not contact lenses) are worn for driving, is the corrective power greater than +8 dioptres in any meridian of either lens?	☐	☐
6	If a correction is worn for driving, is it well tolerated?	☐	☐
7	Is there a history of any medical condition that may affect the applicant's binocular field of vision (central and / or peripheral)?	☐	☐
8	Is there diplopia (controlled or uncontrolled)?	☐	☐
9	Does the applicant, on questioning, report symptoms of intolerance to glare and / or impaired contrast sensitivity and / or impaired twilight vision?	☐	☐
10	Does the applicant have any other ophthalmic condition?	☐	☐

If **YES** to questions 7, 8, 9 or 10 please give details in **Section 7**.

If eye examination has been completed by an Optician or Optometrist please give details below:

Name: Address:

Contact telephone number:

GP or Doctor Signature _____ Date _____

Section 2

NERVOUS SYSTEM

							Yes	No
	Is there any history of, or evidence of, **any** neurological disorder? If **No,** go to section **3**						☐	☐
1	Has the applicant had any form of seizure? If **YES** please answer questions a – f below.						☐	☐
	a	Has the applicant had more than one attack?					☐	☐
	b	Please give date of first and last attack:	*First attack*	DD MM YY	*Last attack*	DD MM YY		
	c	Is the applicant currently on anti-epileptic medication? If **YES** please give details of current medication in **section 7.**					☐	☐
	d	If no longer treated, please give date when treatment ended.				DD MM YY		
	e	Has the applicant had a brain scan? If **YES** please provide date and details in **Section 7**.					☐	☐
	f	Has the applicant had an EEG? If **YES** please provide date and details in **Section 7**					☐	☐
2	Is there a history of blackout or impaired consciousness within the last 5 years? If **YES** please give dates and details at **Section 7**:						☐	☐
3	Does the applicant suffer from narcolepsy? If **YES** please give dates and details in **Section 7.**						☐	☐
4	Is there a history of, or evidence of, any of the conditions listed at a – h below? If **NO** go to **Section 3.**						☐	☐
	If **YES** please give dates and full details in **section 7**.							
	a	Stroke / TIA If **YES** please give date: DD MM YY					☐	☐
		Has there been a **FULL** recovery?					☐	☐
		Has a carotid ultrasound been undertaken?					☐	☐
		If **YES,** was the carotid artery stenosis >50% in either carotid artery?					☐	☐
	b	Sudden and disabling dizziness/vertigo within the last one year with a liability to recur					☐	☐
	c	Subarachnoid haemorrhage					☐	☐
	d	Serious traumatic brain injury within the last 10 years					☐	☐
	e	Any form of brain tumour					☐	☐
	f	Other brain surgery or abnormality					☐	☐
	g	Chronic neurological disorders					☐	☐
	h	Parkinson's disease					☐	☐

GP or Doctor Signature _____ Date _____

Section 3

DIABETES MELLITUS

			Yes ☐	No ☐
Does the applicant have diabetes mellitus? If **NO** please go to Section 4. If **YES** please answer the following questions.				
1	Is the diabetes managed by:-		☐	☐
	a	Insulin? If **YES** please give date started on insulin: DD MM YY	☐	☐
	b	If treated with insulin, are there at least 3 continuous months of blood glucose readings stored in a memory meter? If **NO**, please give details in **Section 7**	☐	☐
	c	Other injectable treatments?	☐	☐
	d	A Sulphonylurea or a Glinide?	☐	☐
	e	Oral hypoglycaemic agents and diet? If **YES** please provide details of medication:	☐	☐
	f	Diet only?	☐	☐
	If **YES** to any of (a) – (e) above, please give details in **Section 7**			
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 or 3 – 5 above, please give details in **Section 7**				
6	Has there been any laser treatment or intra-vitreal for retinopathy? If **YES** please give date(s) of treatment: DD MM YY		☐	☐

GP or Doctor Signature _____ Date _____

Section 4

CARDIAC

4A CORONARY ARTERY DISEASE

	Is there a history of, or evidence of, Coronary Artery Disease? If **NO** please go to Section 4B. If **YES** please answer all questions below and give details at **Section 7** of the form.	**Yes** ☐	**No** ☐
1	Acute coronary syndrome including myocardial infarction? If **YES** please give date(s): DD MM YY	☐	☐
2	Coronary artery by-pass graft surgery? If **YES** please give date(s): DD MM YY	☐	☐
3	Coronary Angioplasty (PCI)? If **YES** please give date of most recent intervention: DD MM YY	☐	☐
4	Has the applicant suffered from angina? If **YES** please give the date of the last known attack: DD MM YY	☐	☐
5	If **YES** to any of the above, are there any physical health problems (eg. Mobility/arthritis. COPD) that would make the applicant unable to undertake 9 minutes of the standard Bruce Protocol ETT?	☐	☐

4B CARDIAC ARRHYTHMIA

		Is there a history of, or evidence of, cardiac arrhythmia? If **NO**, go to Section 4C If **YES** please answer all questions below and give details in **Section 7**.	**Yes** ☐	**No** ☐
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 last 5 years?	☐	☐
2		Has the arrhythmia been controlled satisfactorily for at least 3 months?	☐	☐
3		Has an ICD or biventricular pacemaker (CRST-D type) been implanted?	☐	☐
4		Has a pacemaker been implanted? If **YES**:	☐	☐
	a	Please supply date:		
	b	Is the applicant free of symptoms that caused the device to be fitted?	☐	☐
	c	Does the applicant attend a pacemaker clinic regularly?	☐	☐

GP or Doctor Signature _____ Date _____

4C	PERIPHERAL ARTERIAL DISEASE (EXCLUDING BUERGER'S DISEASE) AORTIC ANEURYSM/DISSECTION					
Is there a history or evidence of **ANY** of the conditions listed at 1 – 5 below? If **NO** go to Section **4D.** If **YES** please answer the questions below and give details in **Section 7**					**Yes** ☐	**No** ☐
1	Peripheral Arterial Disease (excluding Buerger's Disease)				☐	☐
2	Does the applicant have claudication? If **YES,** how long in minutes can the applicant walk at a brisk pace before being symptom limited?:				☐	☐
3	Aortic Aneurysm If **YES:**				☐	☐
	a	Site of Aneurysm (please tick):	Thoracic ☐	Abdominal ☐		
	b	Has it been repaired successfully?			☐	☐
	c	Is the transverse diameter **currently** >5.5cm?			☐	☐
		If **NO** please provide latest measurement:		Date obtained: DD MM YY		
4	Dissection of the Aorta repaired successfully. If **YES,** please provide details in **Section 7**				☐	☐
5	Is there history of Marfan's disease? If **YES**, please provide details in **Section 7**				☐	☐

4D	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 7**			
1	Is there a history of congenital heart disorder?	☐	☐
2	Is there a history of heart valve disease?	☐	☐
3	Is there a history of aortic stenosis?	☐	☐
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)	☐	☐

4E	CARDIAC OTHER		
Does the applicant have a history of **ANY** of the following conditions? If **NO** go to Section 4F. If **YES** please answer **ALL** questions below and give details in **Section 7**		**Yes** ☐	**No** ☐
a	A history of, or evidence of, heart failure?	☐	☐
b	Established cardiomyopathy?	☐	☐
c	Has a left ventricular assist device (LVAD) been implanted?	☐	☐
d	A heart or heart/lung transplant?	☐	☐

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e	Untreated atrial myxoma?	☐	☐

4F	CARDIAC CHANNELOPATHIES		
Is there a history of, or evidence of either of the following conditions? If **No**, go to section 4G		**Yes** ☐	**No** ☐
1	Brugada syndrome?	☐	☐
2	Long QT syndrome?	☐	☐
If **Yes** to either, please give details in **section 7**			

4G	BLOOD PRESSURE (This section must be filled in for all applicants)			
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:			
	1 B.P. reading:	Date: DD MM YY		
	2 B.P. reading:	Date: DD MM YY		
	3 B.P. reading:	Date: DD MM YY		
3	Is there history of malignant hypertension? If **Yes**, please provide details in section 7 (including date of diagnosis and any treatment etc)		Yes ☐	No ☐

4H	CARDIAC INVESTIGATIONS (This section must be filled in for all applicants)			
	Have any cardiac investigations been undertaken or planned? If **No**, go to section 5 If **Yes**, please answer questions 1 - 6		**Yes** ☐	**No** ☐
1	Has a resting ECG been undertaken? If **YES** does it show:		**Yes** ☐	**No** ☐
	a	Pathological Q waves?	☐	☐
	b	Left bundle branch block?	☐	☐
	c	Right bundle branch block?	☐	☐
	If **Yes** to a, b or c please provide details in **section 7**			
2	Has the exercise ECG been undertaken (or planned)?		☐	☐
	If **YES** please provide date and give details in **Section 7** DD MM YY			
3	Has an echocardiogram been undertaken (or planned)?		☐	☐
	a	If **YES** please give date and give details in **Section 7** DD MM YY		
	b	If undertaken is/was the left ventricular ejection fraction greater than or equal to 40%?	☐	☐

GP or Doctor Signature _____ Date _____

4	Has a coronary angiogram been undertaken (or planned)?	☐	☐
	If **YES** please provide date and give details in **Section 7:** DD MM YY		
5	Has a 24 hour ECG tape been undertaken (or planned)?	☐	☐
	If **YES** please provide date and give details in **Section 7** DD MM YY		
6	Has a Myocardial Perfusion Scan or Stress Echo study been undertaken (or planned)?	☐	☐
	If **YES** please provide date and give details in **Section 7** DD MM YY		

Section 5

PSYCHIATRIC ILLNESS

		Yes ☐	No ☐
	Is there a history of, or evidence of **ANY** of the conditions listed at 1 – 9 below? If **NO** please go to Section 6.		
	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 7**. (Please enclose relevant notes). (If applicant remains under specialist clinic(s) please give details in **Section 7**).		
1	Significant psychiatric disorder within the past 6 months?	☐	☐
2	Psychosis or hypomania/mania within the past 3 years, including psychotic depression?	☐	☐
3	Dementia or cognitive impairment?	☐	☐
4	Persistent alcohol misuse in the past 12 months?	☐	☐
5	Alcohol dependence in the past 3 years?	☐	☐
6	Does the applicant show any evidence of being addicted to the excessive use of alcohol?	☐	☐
7	Persistent drug misuse in the past 12 months?	☐	☐
8	Does the applicant show any evidence of being addicted to the excessive use of drugs?	☐	☐
9	Drug dependency in the past 3 years?	☐	☐

GP or Doctor Signature _____ Date _____

Section 6

GENERAL

Please answer all questions in this section. If your answer is **YES** to any question please give full details in **Section 7.**

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. Please give details in **section 7**		
	b	Please answer questions (i) to (vi) for **all** sleep conditions		
	(i)	Date of diagnosis: DD MM YY		
	(ii)	Is it controlled successfully?	**Yes** ☐	**No** ☐
	(iii)	If **Yes** please state treatment:		
	(iv)	Is patient compliant with treatment	**Yes** ☐	**No** ☐
	(v)	Please state period of control:		
	(vi)	Date of last review: DD MM YY		
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, eg. a textphone?	**Yes** ☐	**No** ☐
6		Does the applicant have a history of liver disease of any origin? If **YES** please provide details in **Section 7**.	**Yes** ☐	**No** ☐
7		Is there any history of renal failure? If **YES** please provide details in **Section 7**.	**Yes** ☐	**No** ☐
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	**Yes** ☐	**No** ☐

GP or Doctor Signature _____ Date _____

	driving? If **YES** please provide details of medication and symptoms in **Section 7**		
10	Does the applicant have any other medical condition that could affect safe driving? If **YES** please provide details in **Section 7**	**Yes** ☐	**No** ☐

GP or Doctor Signature _____ Date _____

Section 7

Additional Information

PLEASE ENSURE YOU COMPLETE AND SIGN THE LAST PAGE OF THIS MEDICAL ASSESSMENT

GP or Doctor Signature _____ Date _____

General Practitioner 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 their medical record's then **DO NOT** complete the declaration.

I certify that;

- I have today undertaken a medical examination of the applicant for the purpose of assessing their fitness to act as a driver of a hackney carriage or private hire vehicle under the **DVLA Group 2 Medical Standards**

- I have reviewed the applicant's medical records and that in my opinion nothing therein contradicts or tends to contradict the information given to me by the applicant.

- The medical examination today is satisfactory. From the applicant's medical records and from today's examination, I know of no medical reason where the applicant would be advised to inform the DVLA with regards to driver licensing requirements under Group 2 standards.

Surgery / Medical Centre Name:	Surgery / Medical Centre Stamp: FORM WILL NOT BE ACCEPTED WITHOUT AN OFFICIAL STAMP
Surgery / Medical Centre Address:	
GP's Name: PLEASE PRINT IN BLOCK CAPITALS	
GP's Signature:	Date:

GP or Doctor Signature _____ Date _____