DVLA GROUP 2
MEDICAL EXAMINATION REPORT

HALTON BOROUGH COUNCIL

The requirement for all applicants who wish to hold a licence to drive hackney carriage or private hire vehicles to undertake a medical examination is stated in S57(2)(a), Local Government (Miscellaneous Provisions) Act 1976.

Halton Borough Council has adopted the DVLA Group 2 standard for drivers licensed by this Authority.

Should you be aware of any medical conditions and would like further information before booking an appointment for a medical then go to the following website:

https://www.gov.uk/government/publications/assessing-fitness-to-drive-a-guide-for-medical-professionals

If, after reading the notes, you have any doubts about your ability to meet standards, consult your Doctor/Optician for advice before you arrange for the medical form to be completed.

Halton Borough Council only allows the DVLA Group 2 medicals to be obtained from either:

1. Your own registered medical practitioner (or another registered medical practitioner from the same practice or group practice) who has access to your medical history.

2. Just Health is a private company that has testing centres across the Northwest of England. Visit their website at www.just-health.co.uk or call **01282 936900** to book an appointment.

All fees associated with the medical examination are payable by you and are separate to the licensing fees which are paid to the Council. Please note that no refund is payable in respect of any medical assessment should your application for a licence be refused.

IMPORTANT

Only this approved, fully completed report form will be accepted by Halton Borough Council's licensing section.

If attending a medical examination undertaken by Just Health then you must attend your appointment with the following items otherwise the examination will not go ahead and you may have to pay for a further appointment:

- ★ **A recent summary care record which you must obtain from your own medical centre**
- ★ **Photo identification = Passport or DVLA licence (photo card only)**
- ★ **Any current medication**
- ★ **This medical report form**

This page must be completed by the applicant

Full Name (must include middle names, if held)

Date of Birth

Current Address (this must be where you actually reside and not a postal address!)

Declaration and Authorisation

- I authorise the medical practitioner completing this form to release reports to Halton Borough Council's Licensing Office regarding my medical condition.
- I authorise the use of the information contained within this medical report to be used by Halton Borough Council for the specific purpose of discharging their duties in accordance with current licensing and data protection legislation.
- I declare that the information I have provided on this form and to the medical practitioner as part of this medical assessment is a true and accurate record of my circumstances. Should any of the information be found to be false or misleading then I am aware that I may be prosecuted, have any licence revoked or both.

Signature

Date

Should you have any queries regarding any part of the Licensing process please contact a member of the licensing section.

Halton Borough Council, Licensing Section
4th Floor, Municipal Building, Kingsway, Widnes, Cheshire, WA8 7QF

Email: legalservices@halton.gov.uk

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 are worn for driving, is the corrective power greater than +8 dioptres in any meridian of either lens?	☐	☐
6	If 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 9**

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

Name: Address:

Contact telephone number:

Section 2

NERVOUS SYSTEM							
	Is there any history of, or evidence of, **any** neurological disorder? If **No,** go to section 3					**Yes** ☐	**No** ☐
1	Has the applicant had any form of seizure? If **YES,** please answer questions a – f below.					**Yes** ☐	**No** ☐
	a	Has the applicant had more than one seizure episode?				☐	☐
	b	Please give date of first and last attack:	*First episode*	DD MM YY	*Last episode*	DD MM YY	
	c	Is the applicant currently on anti-epileptic medication? If **YES** please give details of current medication in **section 9**				☐	☐
	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 9**				☐	☐
	f	Has the applicant had an EEG? If **YES** please provide date and details in **Section 9**				☐	☐
2	Has the applicant experienced dissociative/'non-epileptic' seizures?					**Yes** ☐	**No** ☐
	a	If **YES**, please give date of most recent episode. DD MM YY					
	b	If **YES**, have any of these episode(s) occurred or are they considered likely to occur whilst driving?				☐	☐
3	Stroke or TIA? If **YES** please give date(s): DD MM YY					**Yes** ☐	**No** ☐
	a	Has there been a **FULL** recovery?				☐	☐
	b	Has a carotid ultrasound been undertaken?				☐	☐
	c	If **YES,** was the carotid artery stenosis >50% in either carotid artery?				☐	☐
	d	Is there a history of multiple strokes/TIA's?				☐	☐
4	Sudden and disabling dizziness or vertigo within the last year with a liability to recur?					☐	☐
5	Subarachnoid haemorrhage (non-traumatic)?					☐	☐
6	Significant head injury within the last 10 years?					☐	☐
7	Any form of brain tumour?					☐	☐
8	Other intracranial pathology?					☐	☐
9	Chronic neurological disorder(s)?					☐	☐
10	Parkinson's disease?					☐	☐
11	Blackout, impaired consciousness or loss of awareness within the last 10 years?					☐	☐

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(s)? If **NO**, please give details in **Section 9**	☐	☐
	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 of medication in **Section 9**			
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)?	☐	☐
	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	a	Has the applicant ever had a hypoglycaemic episode?	☐	☐
	b	If **YES**, is there full 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 details in **Section 9**		☐	☐
5	Is there evidence of: If **YES** to either of the following questions, please give details in **Section 9**			
	a	Loss of visual field?	☐	☐
	b	Severe peripheral neuropathy, sufficient to impair limb function for safe driving?	☐	☐
6	Has there been any laser treatment or intra-vitreal for retinopathy? If **YES** please give date(s) of treatment: DD MM YY		☐	☐

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 9** of the form.		**Yes** ☐	**No** ☐
1	Has the applicant ever had an episode of angina? If **YES** please give the date of the last known attack: DD MM YY	☐	☐
2	Acute coronary syndrome including myocardial infarction? If **YES** please give date: DD MM YY	☐	☐
3	Coronary Angioplasty (PCI)? If **YES** please give date of most recent intervention: DD MM YY	☐	☐
4	Coronary artery by-pass graft surgery? If **YES** please give date: DD MM YY	☐	☐
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?	☐	☐

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 9**.			**Yes** ☐	**No** ☐
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 last 5 years?		☐	☐
2	Has the arrhythmia been controlled satisfactorily for at least 3 months?		☐	☐
3	Has an ICD (Implanted Cardiac Defibrillator) or biventricular pacemaker with defibrillator/cardiac resynchronisation therapy defibrillator (CRT-D type) been implanted?		☐	☐
4	Has a pacemaker or biventricular pacemaker/ cardiac resynchronisation therapy defibrillator (CRT-P type) been implanted? If **YES**:		☐	☐
	a	Please give date of implantation:		
	b	Is the applicant free of the symptoms that caused the device to be fitted?	☐	☐
	c	Does the applicant attend a pacemaker clinic regularly?	☐	☐

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 9**	**Yes** ☐	**No** ☐
1 Peripheral Arterial Disease (excluding Buerger's Disease)	☐	☐
2 Does the applicant have claudication?	☐	☐
If **YES,** would the applicant be able to undertake 9 minutes of the standard Bruce Protocol ETT?	☐	☐

3	Aortic Aneurysm If **YES:**				☐	☐
	a	Site of Aneurysm (please tick):	Thoracic ☐	Abdominal ☐		
	b	Has it been repaired successfully?			☐	☐
	c	Please provide latest transverse aortic diameter measurement and date obtained using measurement and date boxes.				
		0 . 0 cm	Date obtained: DD MM YY			
4	Dissection of the Aorta repaired successfully?				☐	☐
5	Is there history of Marfan's disease?				☐	☐

4D	**VALVULAR/CONGENITAL HEART DISEASE**		
Is there a history or evidence of valvular or congenital heart disease? If **NO** go to Section 4E. If **YES** please answer all questions below and give details in **Section 9**		**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?	☐	☐
4	Is there any history of embolic stroke?	☐	☐
5	Does the applicant currently have significant symptoms?	☐	☐
6	Has there been any progression (either clinically or on scans etc) since the last licence application?	☐	☐

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 9**		**Yes** ☐	**No** ☐
a	A history of, or evidence of, heart failure?	☐	☐
b	Please provide the NYHA class, if known		
c	Established cardiomyopathy?	☐	☐
d	Has a left ventricular assist device (LVAD) or other cardiac assist device been implanted?	☐	☐
e	A heart or heart/lung transplant?	☐	☐
f	Untreated atrial myxoma?	☐	☐

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

4G	BLOOD PRESSURE (All questions must be answered)			
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.				
1	Please record today's **best resting** blood pressure reading:			
2	Is the applicant on anti-hypertensive treatment? If **YES** please provide three previous readings with dates if available:		Yes ☐	No ☐
	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 9** (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:		☐	☐
	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 9**			
Note: if Yes to the following questions 2 - 7, please give dates next to the question and provide details in section 7				
2	Has an exercise ECG been undertaken (or planned)? DD MM YY		☐	☐
3	Has an echocardiogram been undertaken (or planned)? DD MM YY		☐	☐
	a	If undertaken is or was the left ejection fraction greater than or equal to 40%?	☐	☐
4	Has a coronary angiogram been undertaken (or planned)? DD MM YY		☐	☐
5	Has a 24 hour ECG tape been undertaken (or planned)? DD MM YY		☐	☐
6	Has a loop recorder been implanted (or planned)? DD MM YY		☐	☐
7	Has a Myocardial Perfusion Scan, stress echo study or cardiac MRI been undertaken (or planned)? DD MM YY		☐	☐

Section 5

PSYCHIATRIC ILLNESS				
Is there a history or evidence of psychiatric illness within the last 3 years? If **NO** please go to Section 6. If **YES** please answer the following 3 questions below.			**Yes** ☐	**No** ☐
1	Significant psychiatric disorder within the past 6 months? If **Yes** please confirm condition.		☐	☐
2	Psychosis or hypomania/mania within the past 12 months, including psychotic depression?		☐	☐
3	a	Dementia or cognitive impairment?	☐	☐
	b	Are there concerns which have resulted in ongoing investigations for such possible diagnoses?	☐	☐

Section 6

SUBSTANCE MISUSE				
Is there a history of drug/alcohol misuse or dependence? If **No** go to section 7. If **Yes**, please answer all questions below.			**Yes** ☐	**No** ☐
1	Is there a history of alcohol dependence in the past 6 years?		☐	☐
	a	Is it controlled?	☐	☐
	b	Has the applicant undergone an alcohol detoxification programme? If **Yes**, give date started: DD MM YY	☐	☐
2	Persistent alcohol misuse in the past 3 years?		☐	☐
	a	Is it controlled?	☐	☐
3	Persistent misuse of drugs or other substances in the past 6? years		☐	☐
	a	If **Yes**, the type of substance misused?		
	b	Is it controlled?	☐	☐
	c	Has the applicant undertaken an opiate treatment programme? If **Yes**, give date started: DD MM YY	☐	☐

Section 7

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 8. If **YES** please give diagnosis in box below:		
	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 9**		
	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 applicant compliant with treatment	**Yes** ☐	**No** ☐
	(v)	Please state period of control: How many years and months		
	(vi)	Date of last review: DD MM YY		

Section 8

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?	☐	☐
3	Is there a history of bronchogenic carcinoma or other malignant tumour with a significant liability to metastasise cerebrally?	☐	☐
4	Is there any illness that may cause significant fatigue or cachexia that affects safe driving?	☐	☐
5	Is the applicant profoundly deaf?	☐	☐
	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?	☐	☐
	If **Yes**, is this the result of alcohol abuse? If **Yes** please provide details in **Section 9**	☐	☐
7	Is there any history of renal failure? If **Yes** please provide details in **Section 9**	☐	☐
8	Does the applicant have severe symptomatic respiratory disease causing chronic hypoxia?	☐	☐

9	Does any medication currently taken cause the applicant side effects that could affect safe driving? If **Yes**, please provide details in **Section 9**	**Yes** ☐	**No** ☐
10	Does the applicant have any other medical condition that could affect safe driving? If **Yes**, please provide details in **Section 9**	☐	☐

Section 9

Additional Information

Medical Suitability to Drive in Accordance with DVLA Group 2 Standard

Applicants name

Applicant's address

Applicant's date of birth

I hereby certify that:

☐ The applicant is registered at this medical practice (or group)

☐ The examination has been conducted by Just-Health as approved by Halton Borough Council

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 am currently GMC registered and licensed to practice in the UK

☐ 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.

☐ Following the medical examination today, I am not satisfied that the applicant meets the current requirements under the DVLA's Group 2 medical standards.

Examining Doctor's Signature

Name (block capitals)

GMC Registration Number

Date of Examination

Practice/Surgery/Clinic stamp