MEDICAL EXAMINATION REPORT

APPLICANT'S NAME	DATE OF BIRTH

DIRECTORATE OF ECONOMY AND PLACE – TAXI LICENSING OFFICE

MEDICAL REPORT ON AN APPLICANT FOR A
HACKNEY CARRIAGE OR PRIVATE HIRE DRIVER'S LICENCE

The medical standard prescribed by the City of York Council for the drivers of hackney carriage or private hire vehicles is equivalent to the DVLA's medical standard for Group 2 entitlement. This means that the Group 2 medical standards applied by the DVLA in relation to bus and lorry drivers are also applied to the drivers of hackney carriage and private hire vehicles. This is in line with current best practice advice contained in the booklet "Fitness to Drive":- A Guide for Health Professionals and in the Department for Transport's Taxi and Private Hire Vehicle Licensing: Best Practice Guidance.

A WHAT YOU HAVE TO DO

The medical examination report now includes a vision assessment that must be filled in by a doctor or optician/optometrist. Some doctors will be able to fill in both the vision and medical assessment sections of the report. If your doctor is unable to fully answer all the questions on the vision assessment you must have it filled in by an optician or optometrist. If you do not wear glasses to meet the eyesight standard or if you have a minus (-) eyesight prescription, your doctor may be able to fill in the whole report. If you wear glasses and you have asked your doctor to fill in the report, you must take your current prescription to the assessment.

1. **BEFORE** consulting your Doctor please read the notes at Section C, paragraphs 1, 2, 3 and 4.

   If you have any of these conditions your application may be refused.

2. If, after reading the notes, you have any doubts about your ability to meet the medical or eyesight standards, consult your doctor and/or optician **BEFORE** you arrange for this medical form to be completed. The doctor will normally charge you for completing it. In the event of your application being refused, the fee you pay the doctor is **NOT** refundable.

3. Fill in **Section 11** of this report in the presence of the doctor carrying out the examination.

4. **PLEASE CHECK THAT ALL SECTIONS HAVE BEEN FULLY COMPLETED BEFORE SUBMITTING THE FORM TO THE TAXI LICENSING OFFICE. FAILURE TO DO THIS MAY DELAY YOUR APPLICATION.**

B INFORMATION FOR THE DOCTOR

You must examine the applicant fully and answer sections 1 to 10 of this report. You may find it helpful to consult the DVLA's "At a Glance" booklet. You can download this from the "medical rules for all drivers" section of www.gov.uk/government/publications/at-a-glance

Details of any condition which has not been covered by the report should be given in section 6.

Please only complete the vision assessment if you are able to fully and accurately complete ALL the questions. If you are unable to do this you must tell the applicant that they will need to arrange to have this part of the assessment completed by an optician or optometrist. You must be able to measure the applicant's visual acuity to at least 6/7.5 (decimal 0.8) of a Snellen chart. You must also convert any 3 metre readings to the 6 metre equivalent.

You must also be able to confirm the strength of glasses (dioptres) from a prescription. The applicant has been advised that if they wear glasses to meet the required eyesight standard for driving they must bring their current prescription to the assessment. The spectacle prescription for either lens must not be greater than +8 dioptres. The combination of the sphere and cylinder in a plus prescription must be no greater than plus 8 (+8) dioptres.

If an applicant does not need glasses for driving or if they use contact lenses or if they have a minus (-) dioptre prescription, question 5 of the vision assessment can be answered "No".

C MEDICAL STANDARDS FOR DRIVERS OF HACKNEY CARRIAGE/PRIVATE HIRE VEHICLES

If you have any of the following conditions, your application may be refused.

1. EYESIGHT

All applicants must be able to read in good light with glasses or contact lenses if worn, a car number plate from 20 metres (post 01.09.2001 font) and have eyesight (visual acuity) of 6/12 (decimal Snellen equivalent 0.5) or better.

In addition, **ALL APPLICANTS** for a hackney carriage or private hire driver's licence must also have, as measured by the 6 metre Snellen chart:

- a visual acuity of at least 6/7.5 (decimal Snellen equivalent 0.8) in the better eye
- a visual acuity of at least 6/60 (decimal Snellen equivalent 0.1) in the worse eye
  This may be achieved with or without glasses or contact lenses
- If glasses are worn, the distance spectacle prescription of either lens must not be of a corrective power greater than **plus 8 (+8)** dioptres

Applicants may also be refused the grant of a licence if they have:

- uncontrolled diplopia, i.e. uncontrolled symptoms of double vision or double vision treated with a patch
- or do not have normal binocular field of vision

2. EPILEPSY OR LIABILITY TO EPILEPTIC ATTACKS

If you have been diagnosed as having epilepsy (this includes all events: major, minor and auras), you will need to remain free of seizures without taking anti-epilepsy medication for 10 years.

If you have a condition that causes an increased liability to seizures, for example a serious head injury, the risk of you having a seizure must have fallen to no greater than 2% per annum prior to application.

Isolated Seizure

If you have had only an isolated seizure, you may still be able to pass this medical if the isolated seizure occurred more than 5 years ago, provided that you are able to satisfy the following criteria:

- no relevant structural abnormality has been found in the brain on imaging
- no definite epileptic activity has been found on EEG (record of the brain waves)
- you have not been prescribed medication to treat the seizure for at least 5 years since the seizure
- you have the support of your neurologist
- your risk of a further seizure is considered to be 2% or less per annum (each year).

You are strongly advised to discuss your ability to satisfy this criteria before getting the medical report form filled in.

3. INSULIN TREATED DIABETES

If you have insulin treated diabetes, you may be able to pass this medical if you meet the strict criteria for controlling and monitoring your diabetes. This includes having at least 3 months of blood glucose readings available for inspection on a blood glucose meter(s) with a memory function. An annual assessment by a hospital consultant specialising in the treatment of diabetes will be required.

In addition, it is highly likely that a referral will be made to the Council's Occupational Health Advisors and you may be required to attend an appointment with them.

4. OTHER MEDICAL CONDITIONS

In addition to the above medical conditions, an applicant or existing licence holder is likely to be refused the grant of a licence if they cannot meet the recommended medical guidelines for any of the following:

- within 3 months of a coronary artery bypass graft (CABG)
- angina, heart failure or cardiac arrhythmia which remains uncontrolled
- implanted cardiac defibrillator
- hypertension where the blood pressure is persistently 180 systolic or more and/or 100 diastolic or more
- a stroke or transient ischemic attack (TIA) within the last 12 months
- unexplained loss of consciousness with liability to recurrence
- Meniere's disease, or any other sudden and disabling vertigo within the past year, with a liability to recurrence
- major brain surgery and/or recent severe head injury with serious continuing after-effects or a likelihood of causing seizures
- Parkinson's disease, multiple sclerosis or other chronic neurological disorders with symptoms likely to affect safe driving
- psychotic illness in the past 3 years
- serious psychiatric illness
- if major psychotropic or neuroleptic medication is being taken
- alcohol and/or drug misuse in the past 1 year or alcohol and/or drug dependence in the past 3 years
- dementia
- cognitive impairment likely to affect safe driving
- any malignant condition in the last 2 years, with a significant liability to metastasise (spread) to the brain
- any other serious medical condition likely to affect the safe driving of a hackney carriage or private hire vehicle
- cancer of the lung

Medical Examination Report

VISION ASSESSMENT

To be completed by a doctor or optician/optometrist (please read notes on pages 1 & 2)

The visual acuity, as measured by the 6 metre Snellen chart, must be at least 6/7.5 (decimal Snellen equivalent 0.8) in the better eye and at least Snellen 6/60 (decimal Snellen equivalent 0.1) in the other eye. Corrective lenses may be worn to achieve this standard.

If correction is needed to meet the eyesight standard for driving, ALL questions must be answered. If correction is NOT needed, questions 4 and 5 can be ignored.

YES ☐ **NO** ☐

1. Is the visual acuity as measured by the Snellen chart **AT LEAST** 6/7.5 in the better eye and **AT LEAST** 6/60 in the other? (corrective lenses may be worn)

2. Please state the visual acuity of each eye

UNCORRECTED

Right ☐ **Left** ☐

CORRECTED
(Using the prescription worn for driving)

Right ☐ **Left** ☐

3. Please give the best binocular acuity (with corrective lenses if worn for driving) ☐

YES ☐ **NO** ☐

4. If **glasses** were worn, was the distance spectacle prescription of either lens used of a corrective power greater than plus 8 (+8) dioptres?

YES ☐ **NO** ☐

5. If a correction is worn for driving, is it well tolerated?

If you answer Yes to ANY of the following, please give details in the box provided.

YES ☐ **NO** ☐

6. Is there a history of any medical condition that may affect the patient's binocular field of vision (central and/or peripheral)?

YES ☐ **NO** ☐

7. Is there diplopia?

If **Yes**, is it controlled? ☐ ☐

If **Yes**, please give full details in the box provided.

YES ☐ **NO** ☐

8. Is there any reason to believe that there is impairment of contrast sensitivity or intolerance to glare?

YES ☐ **NO** ☐

9. Does the patient have any other ophthalmic condition?

Details

Medical Examination Report

MEDICAL ASSESSMENT

SECTION 1 – NERVOUS SYSTEM

1. Has the patient had any form of seizure? YES ☐ NO ☐

If **NO**, please go to **question 2**
If **YES**, please answer questions a-f

(a) Has the patient had more than one attack? YES ☐ NO ☐

(b) Please give date of first and last attack

First attack ☐

Last attack ☐

(c) Is the patient currently on anti-epileptic medication? YES ☐ NO ☐
*If **YES**, please fill in current medication in **section 8***

(d) If no longer treated, please give date when treatment ended ☐

(e) Has the patient had a brain scan? YES ☐ NO ☐
*If **YES**, please give details in **section 6***

(f) Has the patient had an EEG YES ☐ NO ☐

If **YES** to any of above, please supply further details in **section 6**

2. Is there a history of blackout or impaired consciousness within the last 5 years? YES ☐ NO ☐
*If **YES**, please give date(s) and details in **section 6***

3. Does the patient suffer from narcolepsy or cataplexy? YES ☐ NO ☐
If **YES,** please *give date(s) and details in **section 6***

4. Is there a history of, or evidence of, **ANY** conditions listed at a-h? YES ☐ NO ☐

If **NO**, please go to **section 2**
If **YES**, please give full details in **section 6**

	YES	NO
(a) Stroke or TIA	☐	☐
If **YES**, please give date ☐		
Has there been a **full** recovery?	☐	☐
Has a carotid ultra sound been undertaken?	☐	☐
(b) Sudden and disabling dizziness/vertigo within the last 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	☐	☐

	YES	NO
(f) Other brain surgery or abnormality		
(g) Chronic neurological disorders		
(h) Parkinson's disease		

SECTION 2 – DIABETES MELLITUS

	YES	NO
1. Does the patient have diabetes mellitus?		

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

2. Is the diabetes managed by:-

	YES	NO
(a) Insulin?		

If **YES**, please give date started on insulin

	YES	NO
(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**

	YES	NO
(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**

	YES	NO
(f) Diet only?		

	YES	NO
3. (a) Does the patient test blood glucose at least twice every day?		
(b) Does the patient test at times relevant to driving?		
(c) Does the patient keep fast acting carbohydrate within easy reach when driving?		
(d) Does the patient have a clear understanding of diabetes and the necessary precautions for safe driving?		

	YES	NO
4. Is there any evidence of impaired awareness of hypoglycaemia?		

	YES	NO
5. Is there a history of hypoglycaemia in the last 12 months requiring the assistance of another person?		

6. Is there evidence of:-

	YES	NO
(a) Loss of visual field?		
(b) Severe peripheral neuropathy, sufficient to impair limb function for safe driving?		

If **YES** to any of questions 4-6 above, please give details in **section 6**

		YES	NO
7.	Has there been laser treatment or intra-vitreal treatment for retinopathy?		

If **YES**, please give date(s) of treatment

SECTION 3 – PSYCHIATRIC ILLNESS

Is there a history of, or evidence of, **ANY** of the conditions listed at 1-7 below?

If patient remains under specialist clinic(s), please ensure details are filled in at **section 7**.

		YES	NO
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.	Persistent drug misuse in the past 12 months		
7.	Drug dependence in the past 3 years		

If YES to ANY of questions 4-7, please state how long this has been controlled

Please give details of past consumption or name of drug(s) and frequency

SECTION 4 – CARDIAC

4A Coronary Artery Disease

	YES	NO
Is there a history of, or evidence of, coronary artery disease?		

If **NO**, go to **section 4B**
If **YES**, please answer all questions below and give details in **section 6**

		YES	NO
1.	Has the patient suffered from Angina?		

If **YES**, please give the date of the last known attack

		YES	NO
2.	Acute coronary syndromes including Myocardial infarction?		

If **YES**, please give date

		YES	NO
3.	Coronary angioplasty (P.C.I.)		
	If **YES**, please give date of most recent intervention		
4.	Coronary artery by-pass graft surgery?		
	If **YES**, please give date		

4B Cardiac Arrhythmia

		YES	NO
	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 6**

		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 the 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 of implantation		
	(b) Is the patient free of symptoms that caused the device to be fitted?		
	(c) Does the patient attend a pacemaker clinic regularly?		

4C Peripheral Arterial Disease (excluding Buerger's Disease) Aortic Aneurysm/Dissection

		YES	NO
	Is there a history of, or evidence of, **ANY** of the following:		

If **NO**, go to **section 4D**
If **YES**, please answer all questions below and give details in **section 6**

		YES	NO
1.	Peripheral arterial disease (excluding Buerger's disease)		
2.	Does the patient have claudication?		

If **YES**, how long in minutes can the applicant walk at a brisk pace before being symptom-limited? Please give details below.

		YES	NO
3.	Aortic aneurysm	☐	☐

If **YES**

(a) Site of aneurysm

Thoracic ☐

Abdominal ☐

	YES	NO
(b) Has it been repaired successfully?	☐	☐
(c) Is the transverse diameter **currently** > 5.5cm?	☐	☐

If **NO**, please provide latest measurement and date obtained

Measurement ☐ Date ☐

		YES	NO
4.	Dissection of the aorta repaired successfully	☐	☐
5.	Is there a history of Marfan's disease?	☐	☐

4D Valvular/Congenital Heart Disease

	YES	NO
Is there a history of, or evidence of, valvular/congenital heart disease?	☐	☐

If **NO**, go to **section 4E**
If **YES**, please answer all questions below and give details in **section 6**

		YES	NO
1.	Is there a history of congenital heart disorder?	☐	☐
2.	Is there a history of heart valve disease?	☐	☐
3.	Is there any history of embolism? (**not** pulmonary embolism)	☐	☐
4.	Does the patient currently have significant symptoms?	☐	☐

4E Cardiac – other

	YES	NO
Does the patient have a history of **ANY** of the following conditions:	☐	☐

If **NO**, go to **section 4F**
If **YES**, please answer **ALL** questions and give details in **section 6**

	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?	☐	☐
(e) untreated atrial myxoma	☐	☐

4F Cardiac Investigations

This section must be filled in for all patients

		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 comment in **section 6**		

		YES	NO
2.	Has an exercise ECG been undertaken (or planned)?		
	If **YES**, please give date and give details in **section 6**		

		YES	NO
3.	Has an echocardiogram been undertaken (or planned)?		
	(a) If **YES**, please give date and give details in **section 6**		
	(b) If undertaken, is/was the left ejection fraction greater than or equal to 40%?		

		YES	NO
4.	Has a coronary angiogram been undertaken (or planned)?		
	If **YES**, please give date and give details in **section 6**		

		YES	NO
5.	Has a 24 hour ECG tape been undertaken (or planned)?		
	If **YES**, please give date and give details in **section 6**		

		YES	NO
6.	Has a myocardial perfusion scan or stress echo study been undertaken (or planned)?		
	If **YES**, please give date and give details in **section 6**		

4G Blood Pressure

1. Please record today's blood pressure reading

		YES	NO
2.	Is the patient on anti-hypertensive treatment?		

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

Reading	Date

		YES	NO
3.	If treated, does the medication cause side effects likely to affect safe driving?		

SECTION 5 – GENERAL

Please answer **ALL** questions. If **YES** to any questions, please 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 patient profoundly deaf? YES ☐ NO ☐

If **YES**, is the patient able to communicate in the event of an emergency by speech or by using a device, e.g. a textphone? ☐ ☐

5. Does the patient 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. (a) Is there a history of, or evidence of, obstructive sleep apnoea syndrome YES ☐ NO ☐

(b) Is there any other **medical condition** causing excessive daytime sleepiness? ☐ ☐

If **YES**, please give diagnosis

☐

If **YES** to 7a or b, please give

(i) Date of diagnosis ☐

(ii) Is it controlled successfully? ☐ ☐

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

☐

(iv) Please state period of control

☐

(v) Date last seen by consultant ☐

8. Does the patient have severe symptomatic respiratory disease causing chronic hypoxia? YES ☐ NO ☐

9. Does any medication currently taken cause the patient side effects that could affect safe driving? YES ☐ NO ☐

If **YES**, please provide details of medication and symptoms in **section 6**

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

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

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

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

12. It is a requirement of being a licensed hackney carriage or private hire vehicle driver that the driver assists customers with luggage, assists customers in wheelchairs and places luggage and wheelchairs in the vehicle.

	YES	NO
Is there currently any functional impairment that is likely to affect the applicant from carrying out these tasks?	☐	☐

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

SECTION 6 – FURTHER DETAILS

SECTION 7 – CONSULTANTS' DETAILS

Details of type of specialist(s)/consultant(s) including address.

Consultant's Name:	Consultant in:
Address:	
	Date of last appointment:

Consultant's Name:	Consultant in:
Address:	
	Date of last appointment:

SECTION 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

SECTION 9 – ADDITIONAL INFORMATION

Patient's weight	
Patient's height	
Details of smoking habits, if any	

MEDICAL PRACTITIONER DETAILS

To be completed by the Doctor carrying out the examination

SECTION 10

SURGERY STAMP

Name
Address

NOTE: THIS FORM MUST BE STAMPED

The person named below has been subject to a medical examination to the Group 2 medical standards prescribed by DVLA for drivers of medium/large goods vehicles or passenger carrying vehicles.

The medical examination has been carried out with reference to the patient's current medical records.

The person named below has *PASSED / FAILED the medical examination and *IS / IS NOT judged to be fit to provide a public transport service as a driver of a hackney carriage/private hire vehicle.

*** delete as appropriate**

Signature of Medical Practioner		**Date of examination**	

PATIENT'S DETAILS

To be completed in the presence of the Doctor carrying out the examination

SECTION 11

Your name		Date of birth	
Your address		Home telephone no.	
		Mobile telephone no.	

About your GP/Group Practice

GP/Group Name Address

Telephone No: