ST HELENS
BOROUGH COUNCIL

# GROUP 2 MEDICAL ASSESSMENT

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

**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: _____ Postcode: _____

I hereby authorise my doctor(s) and specialists to release reports/medical information to the Medical Practitioner, should they require further information about condition(s) relevant to my fitness to drive to group 2 standard.

| **Signature of Applicant** | Signed: | Date: |
|---|---|---|

The applicant has provided me the following form of identification:

Driving Licence ❑ Passport ❑ Birth Certificate ❑ HM Forces ID Card ❑

You are Assessing Fitness to Drive at DVLA Group 2 Standard, a guidance for medical professionals is available online at https://www.gov.uk/guidance/assessing-fitness-to-drive-a-guide-for-medical-professionals This medical must be completed in person and not remotely.

**Medical certification frequency requirement**

- A new certificate must be produced every 5 years after the applicant's 45th birthday.
- Once the age of 65 is reached, a medical certificate must be produced every year.

**Earlier medical certification frequency requirement**

The above medical certification frequency is not sufficient: ❑ (tick box **if applicable**) and I recommend that the applicant is examined no later than: (insert date) _____

❑ I certify that I have on this day examined the applicant, who signed this form in my physical presence and showed two forms of identification as indicated above and they have provided me with their full medical records obtained within the last month for which I have reviewed to ascertain their medical fitness to Group 2 Standards and I declare that they meet the below:

**Medically Fit** ❑ **Medically Unfit** ❑ to drive a hackney carriage or private hire vehicle.

Name of GMC registered Medical Practitioner _____

Signature of GMC registered Medical Practitioner _____ Date _____

| GMC Reference Number | | | | | | | |
|---|---|---|---|---|---|---|---|

Please add address and phone number
or Medical Practice Address Stamp
**No disclaimers are acceptable.**

**PLEASE ENSURE YOU COMPLETE AND SIGN THE ADDITONAL INFORMATION PAGE OVERLEAF**

## Additional Information

Please note any relevant medical information about the applicant here that would normally be noted in section 7 of the standard Group 2 Medical form.

GP 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:<br>☐ 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?<br>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 the **Additional Information** section.

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

Name: Address:

Contact telephone number:

GP Signature _____ Date _____

## Section 2

### NERVOUS SYSTEM

| | | | Yes | No |
|---|---|---|---|---|
| | Is there any history of, or evidence of, **any** neurological disorder?<br>If **No,** go to section **3** | | ☐ | ☐ |
| 1 | Has the applicant had any form of seizure?<br>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?<br>If **YES** please give details of current medication in the **Additional Information** section**.** | ☐ | ☐ |
| | 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 the **Additional Information** section. | ☐ | ☐ |
| | f | Has the applicant had an EEG? If **YES** please provide date and details in the **Additional Information** section. | ☐ | ☐ |
| 2 | Is there a history of blackout or impaired consciousness within the last 5 years? If **YES** please give dates and details in the **Additional Information** section. | | ☐ | ☐ |
| 3 | Does the applicant suffer from narcolepsy? If **YES** please give dates and details in the **Additional Information** section | | ☐ | ☐ |
| 4 | Is there a history of, or evidence of, any of the conditions listed at a – h below?<br>If **NO** go to **Section 3.** | | ☐ | ☐ |
| | If **YES** please give dates and full details in the **Additional Information** section. | | | |
| | a | Stroke / TIA<br>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 Signature _____ Date _____

**Section 3**

## DIABETES MELLITUS

| | | | Yes ☐ | No ☐ |
|---|---|---|---|---|
| Does the applicant have diabetes mellitus?<br>If **NO** please go to Section 4.<br>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 the **Additional Information** section. | ☐ | ☐ |
| | 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 the **Additional Information** section. | | | |
| 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 the **Additional Information** section. | | | | |
| 6 | Has there been any laser treatment or intra-vitreal for retinopathy?<br>If **YES** please give date(s) of treatment: DD MM YY | | ☐ | ☐ |

GP 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 in the **Additional Information** section. | **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 the **Additional Information** section. | **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 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?<br>If **NO** go to Section **4D.** If **YES** please answer the questions below and give details in the **Additional Information** section | | | | | **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 the **Additional Information** section. | | | | ☐ | ☐ |
| 5 | Is there history of Marfan's disease? If **YES**, please provide details in the **Additional Information** section. | | | | ☐ | ☐ |

| 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 the **Additional Information** section. | | | |
| 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?<br>If **NO** go to Section 4F. If **YES** please answer **ALL** questions below and give details in the **Additional Information** section. | | **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? | ☐ | ☐ |

GP Signature _____ Date _____

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

| 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?<br>If **Yes**, please provide details in the **Additional Information** section (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?<br>If **No**, go to section 5<br>If **Yes**, please answer questions 1 - 6 | **Yes** ☐ | **No** ☐ |
| 1 | Has a resting ECG been undertaken?<br>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 the **Additional Information** section | | |
| 2 | Has the exercise ECG been undertaken (or planned)? | ☐ | ☐ |
| | If **YES** please provide date and give details in the **Additional Information** section DD MM YY | | |
| 3 | Has an echocardiogram been undertaken (or planned)? | ☐ | ☐ |
| | a If **YES** please give date and give details in the **Additional Information** section DD MM YY | | |
| | b If undertaken is/was the left ventricular ejection fraction greater than or equal to 40%? | ☐ | ☐ |

GP Signature _____ Date _____

| | | | |
|---|---|---|---|
| 4 | Has a coronary angiogram been undertaken (or planned)? | ☐ | ☐ |
| | If **YES** please provide date and give details in the **Additional Information** section**:** DD MM YY | | |
| 5 | Has a 24 hour ECG tape been undertaken (or planned)? | ☐ | ☐ |
| | If **YES** please provide date and give details in the **Additional Information** section 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 the **Additional Information** section 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?<br>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 the **Additional Information** section. (Please enclose relevant notes). (If applicant remains under specialist clinic(s) please give details in the **Additional Information** section). | | | |
| 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 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 the **Additional Information** section**.**

| | | | | |
|---|---|---|---|---|
| 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<br>Mild (AHI<15) ☐<br>Moderate (AHI 15 – 29) ☐<br>Severe (AHI >29) ☐<br>Not known ☐<br>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 the **Additional Information** section. | | |
| | 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?<br>If **YES** please provide details in the **Additional Information** section. | | **Yes** ☐ | **No** ☐ |
| 7 | Is there any history of renal failure?<br>If **YES** please provide details in the **Additional Information** section. | | **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 driving? | | **Yes** ☐ | **No** ☐ |

GP Signature _____ Date _____

| | | | |
|---|---|---|---|
| | If **YES** please provide details of medication and symptoms in the **Additional Information** section. | | |
| 10 | Does the applicant have any other medical condition that could affect safe driving?<br>If **YES** please provide details in the **Additional Information** section. | **Yes** ☐ | **No** ☐ |

GP Signature _____ Date _____