MEDICAL EXAMINATION REPORT FOR HACKNEY CARRIAGE AND PRIVATE HIRE DRIVERS

When completed, please return this form with your application or renewal application to:

CHORLEY COUNCIL
PUBLIC PROTECTION TEAM (LICENSING)
PEOPLE & PLACES DIRECTORATE
CIVIC OFFICES, UNION STREET
CHORLEY, PR7 1AL

MEDICAL EXAMINATION REPORT

To be completed by the Doctor (please use black ink)

Please give patient's weight (kg/st) [ ] Height (cms/ft) [ ]

Please give details of smoking habits, if any [ ]

Please give number of alcohol units taken each week [ ]

Is the urine analysis positive for Glucose? No [ ] Yes [ ] (please tick appropriate box)

Details of specialist(s)/ consultants, including address	1	2	3
Speciality			
Date last seen			

Current medication including exact dosage and reason for each treatment [ ]

Date when first licensed to drive a taxi/PH vehicle [ ] And/or lorry [ ] And/or bus [ ]

1 Vision

Please tick the appropriate boxes	**YES**	**NO**
1. Is the visual acuity **at least** 6/9 in the better eye and at least 6/12 in the other? (corrective lenses may be worn) as measured with the full size 6m Snellen chart	☐	☐
2. Do corrective lenses have to be worn to achieve this standard?	☐	☐
If **YES,** is the:-		
a) uncorrected acuity at least 3/60 in the right eye?	☐	☐
b) uncorrected acuity at least 3/60 in the left eye? (3/60 being the ability to read the 6/60 line of the full size 6m Snellen chart at 3 metres)	☐	☐
c) correction well tolerated?	☐	☐

Please tick the appropriate boxes | **YES** | **NO**

3. Please state the visual acuities **of each eye** in terms of the 6m Snellen chart.
Please convert any 3 metre readings to the 6 metre equivalent.

Uncorrected				**Corrected (if applicable)**			
Right		Left		Right		Left	

4. Is there a defect in his/her binocular field of vision (central and/or peripheral)? ☐ ☐

5. Is there diplopia? (controlled or uncontrolled)? ☐ ☐

6. Does the applicant have any other ophthalmic condition? ☐ ☐

If **YES** to 4, 5 or 6, please give details in Section 7 and enclose any relevant visual field charts or hospital letters.

2 Nervous System

Please tick the appropriate boxes | **YES** | **NO**

1. Has the applicant had any form of epileptic attack? ☐ ☐

a) If Yes, please give date of last attack	D D	M M	Y Y
b) If treated, please give date when treatment ceased	D D	M M	Y Y

c) Is the applicant currently on anti-epileptic medication? ☐ ☐
If **YES,** please complete current medication on the appropriate section of the front of this form

2. Is there a history of blackout or impaired consciousness within the last 5 years? ☐ ☐
If **YES,** please give date(s) and details in **Section 7**

3. Does the applicant suffer from narcolepsy/cataplexy? ☐ ☐
If **YES,** please give 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 tick the relevant box(es) and give dates and full details at **Section 7.**

a) Stroke/TIA *please delete as appropriate* ☐

b) Sudden and disabling dizziness/vertigo within the last 1 year with a liability to recur ☐

c) Subarachnoid haemorrhage ☐

d) Serious head injury within the last 10 years ☐

e) Brain tumour, either benign or malignant, primary or secondary ☐

f) Other brain surgery ☐

g) Chronic neurological disorders e.g. Parkinson’s disease, Multiple Sclerosis ☐

h) Dementia or cognitive impairment ☐

3 Diabetes Mellitus

Please tick > the appropriate boxes | **YES** | **NO**

1. Does the applicant have diabetes mellitus? ☐ ☐
If **NO,** please proceed to **Section 4**
If **YES,** please answer the following questions.

Please tick the appropriate boxes YES NO

2. Is the diabetes managed by:-
a) Insulin? ☐ ☐

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

DD	MM	YY

b) Oral hypoglycaemic agents and diet? ☐ ☐
If YES, please complete current medication on the appropriate section on the front of this form

c) Diet only? ☐ ☐

3. Does the applicant test blood glucose at least twice every day? ☐ ☐

4. Is there evidence of:-
a) Loss of visual field? ☐ ☐

b) Severe peripheral neuropathy, sufficient to impair limb function for safe driving? ☐ ☐

c) Diminished/Absent awareness of hypoglycaemia? ☐ ☐

5. Has there been laser treatment for retinopathy? ☐ ☐

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

6. Is there a history of hypoglycaemia during **waking** hours in the last
12 months requiring assistance from a third party? ☐ ☐

If **YES** to any of 4-6 above, please give details in **Section 7**

4 Psychiatric Illness

Please tick > the appropriate boxes YES NO

Is there a history of, or evidence of any of the conditions listed at 1-6 below? ☐ ☐
If NO, please go to **Section 3**
If YES, please tick the relevant box(es) below and give date(s), prognosis, period of stability and details of medication, dosage and any side effects in **Section 7.**
NB. If applicant remains under specialist clinic(s) ensure details are completed at the top of page 1.

1. Significant psychiatric disorder within the past 6 months ☐

2. A psychotic illness within the past 3 years, including psychotic depression ☐

3. Persistent alcohol misuse in the past 12 months ☐

4. Alcohol dependency in the past 3 years ☐

5. Persistent drug misuse in the past 12 months ☐

6. Drug dependency in the past 3 years ☐

NB. Please enclose relevant hospital notes with reference to this condition

5 Cardiac

Please follow the instructions in all sections (5A-5G) giving details as required in Section 7 and enclose hospital notes relevant to this condition.

NB. If applicant remains under specialist cardiac clinic(s) ensure details are completed on page 5.

5A Coronary Artery Disease

Please tick the appropriate boxes **YES** **NO**

Is there a history of, or evidence of, coronary artery disease? ☐ ☐
If NO, proceed to **Section 5B**
If YES please answer all questions below and give details at **Section 7** of the form.

1. Acute Coronary Syndrome including Myocardial Infarction? ☐ ☐

If **YES**, please give date(s) | DD | MM | YY |

2. Coronary artery by-pass graft? ☐ ☐

If **YES**, please give date(s) | DD | MM | YY |

3. Coronary Angioplasty (P.C.I) ☐ ☐

If **YES**, please give date(s) | DD | MM | YY |

4. Has the applicant suffered from Angina? ☐ ☐

If **YES**, please give the date of the last attack | DD | MM | YY |

Please proceed to next Section 5B

5B Cardiac Arrhythmia

Please tick the appropriate boxes **YES** **NO**

Is there a history of, or evidence of, cardiac arrhythmia? ☐ ☐
If NO, proceed to **Section 5C**
If YES please answer all questions below and give details at **Section 7** of the form.

1. Has the applicant had a significant documented disturbance of cardiac rhythm within the past 5 years? ☐ ☐

2. Has the arrhythmia been controlled satisfactorily for at least 3 months? ☐ ☐

3. Has a cardiac defibrillator device (I.C.D) been implanted ☐ ☐

4. Has a pacemaker been implanted? ☐ ☐
If **YES:-**
a) Has the pacemaker been implanted for at least 6 weeks? ☐ ☐

b) Since implantation of the pacemaker, is the applicant now symptom free as a result? ☐ ☐

c) Does the applicant attend a pacemaker clinic regularly? ☐ ☐

Please proceed to next Section 5C

5C Peripheral Arterial Disease

Please tick the appropriate boxes **YES** **NO**

1. Is there a history or evidence of ANY of the below: ☐ ☐
If **YES** please **tick** > ALL relevant boxes below, and give details at **Section 7** of the form.

PERIPHERAL ARTERIAL DISEASE ☐ ☐
AORTIC ANEURYSM
IF YES:
a) Site of Aneurysm: **Thoracic** ☐ **Abdominal** ☐

b) Has it been repaired successfully? ☐ ☐

c) Is the transverse diameter more than 5cms? ☐ ☐

Please tick the appropriate boxes YES NO

DISSECTION OF THE AORTA ☐ ☐
IF YES:
d) Has it been repaired successfully? ☐ ☐

Please proceed to next Section 5D

5D Valvular/Congenital Heart Disease

Please tick > the appropriate boxes YES NO

Is there a history of, or evidence of, valvular/congenital heart disease? ☐ ☐
If NO, proceed to **Section 5E**
If YES please answer all questions below and give details at **Section 7** of the form.
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 applicant currently have significant symptoms? ☐ ☐

5. Has there been any progression since the last licence application? (if relevant) ☐ ☐

Please proceed to next Section 5E

5E Cardiomyopathy

Please tick the appropriate boxes YES NO

Does the applicant have a history of ANY of the following conditions: ☐ ☐

a) a history of, or evidence of heart failure?

b) established cardiomyopathy?

c) a heart or heart/lung transplant?

If YES to any part of the above, please give full details in Section 7 of the form. If NO proceed to next Section 5F.

5F Cardiac Investigations

Please tick the appropriate boxes YES NO

This section must be completed for all applicants.

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? ☐ ☐

2. Has an exercise ECG been undertaken (or planned)? ☐ ☐

If **YES**, please give date and give details in **Section 7** | D D | M M | Y Y |
Sight/copy of the exercise test result/report (if done in the last 3 years) would be helpful

Please tick the appropriate boxes **YES** **NO**

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%? ☐ ☐
Sight/copy of the echocardiogram result/report would be helpful

4. Has a coronary angiogram been undertaken (or planned)? ☐ ☐

If **YES**, please give date and give details in **Section 7** | DD | MM | YY |
Sight/copy of the angiogram result/report would be helpful

5. Has a 24 hour ECG tape been undertaken (or planned)? ☐ ☐

If **YES**, please give date and give details in **Section 7** | DD | MM | YY |
Sight/copy of the 24 hour tape result/report would be helpful

6. Has a myocardial perfusion scan or stress echo study been undertaken (or planned)? ☐ ☐

If **YES**, please give date and give details in **Section 7** | DD | MM | YY |
Sight/copy of the scan result/report would be helpful

Please proceed to Section 5G

5G Blood Pressure

Please tick the appropriate boxes **YES** **NO**

This section must be completed for all applicants.

1. Is today's resting systolic pressure 180mm Hg or greater? ☐ ☐

2. Is today's resting diastolic pressure 100mm Hg or greater? ☐ ☐

3. Is the applicant on anti-hypertensive treatment? ☐ ☐

If YES, to any of the above, please supply today's reading and three previous readings and dates.

6 General

Please tick the appropriate boxes **YES** **NO**

Please answer all questions in this section. If your answer is 'YES' to any of the questions, please give full details in Section 7.

1. Is there **currently** a disability of the spine or limbs, likely to impair control of the vehicle? ☐ ☐

2. Is there a history of bronchogenic carcinoma or other malignant tumour, for example, malignant melanoma, with a significant liability to metastasise cerebrally? ☐ ☐

If **YES**, please give dates and diagnosis and state whether there is current evidence of dissemination.

Please tick the appropriate boxes **YES** **NO**

3. Is the applicant profoundly deaf? ☐ ☐
If **YES,**
is he/she able to communicate in the event of an emergency by speech or by using a device, e.g. a MINICOM/text phone? ☐ ☐

4. Is there a history of either renal or hepatic failure? ☐ ☐

5. Does the applicant have sleep apnoea syndrome? ☐ ☐
If **YES,** please supply details

a) Date of diagnosis DD MM YY

b) Is it controlled successfully? ☐ ☐

c) If **YES**, please state treatment ______ d) Please state period of control ______

6. Is there any other **Medical Condition**, causing excessive daytime sleepiness? ☐ ☐
If **YES,** please supply details

a) Diagnosis ______

b) Date of diagnosis DD MM YY

c) Is it controlled successfully? ☐ ☐

d) If **YES**, please state treatment ______ e) Please state period of control ______

7. Does the applicant have severe symptomatic respiratory disease causing chronic hypoxia? ☐ ☐

8. Does any medication currently taken cause the applicant side effects that could affect safe driving? ☐ ☐
If **YES,** please supply details of medication

______

9. Does the applicant have any other medical condition that could affect safe driving? ☐ ☐
If **YES,** please supply details

______

THIS SECTION IS INTENTIONALLY BLANK

7 Please forward copies of relevant hospital notes **only**.
PLEASE DO NOT send any notes not related to fitness to drive.

8 Applicant's consent and declaration

Consent and Declaration

This section MUST be completed and must **NOT** be altered in any way.
Please read the following important information carefully then sign the statements below.

Important information about Consent

On occasion, as part of the investigation into your fitness to drive, Chorley Council, may require you to undergo a medical examination or some form of practical assessment. In these circumstances, those personnel involved will require your background medical details to undertake an appropriate and adequate assessment. Such personnel might include doctors, orthoptists at eye clinics or paramedical staff at a driving assessment centre. Only information relevant to the assessment of your fitness to drive will be released. In addition, where the circumstances of your case appear exceptional, the relevant medical information would need to be considered by one or more of the Secretary of State's Honorary Medical Advisory Panels. The membership of these Panels conforms strictly to the principle of confidentiality.

Consent and Declaration

I authorise my Doctor(s) and Specialist(s) to release report/medical information about my condition, relevant to my fitness to drive, to the Secretary of State's medical adviser.

I authorise the Secretary of State to disclose such relevant medical information as may be necessary to the investigation of my fitness to drive, to doctors, paramedical staff and Panel members, and to inform my doctor(s) of the outcome of the case where appropriate.

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."

Signature | **Date**

Applicant's Details

To be completed in the presence of the
Medical Practitioner carrying out the examination

9 Your details

Your full name	
Your address	
Email address	

Date of Birth	DD	MM	YY
Home tel. no.			
Work/Day no.			

About your GP/Group Practice

GP/Group name	
Address	
Telephone	
Email address	
Fax number	

Medical Practitioner Details

To be completed by Doctor carrying out the examination

10 Doctor's details

Name	
Address	
Email address	
Fax number	

Surgery Stamp

I confirm that: ______________________ is registered with this Doctors Practice and I have checked and have had access to their medical history.

I consider the above named person to be medically **FIT** ☐ **UNFIT** ☐ to undertake the duties of a Hackney Carriage/Private Hire Driver.

Signature of Medical Practitioner ______________________ **Date** ______________