

THIS FORM MUST BE COMPLETED BY YOUR REGISTERED GP OR VIA  
D4DRIVERS: <https://d4drivers.uk/taxi-medical/>

# Havant

## BOROUGH COUNCIL

Licensing  
Public Service Plaza  
Civic Centre Road  
Havant  
Hampshire  
PO9 2AX

### MEDICAL PRACTITIONER DETAILS

*To be completed by the medical practitioner carrying out the medical examination.*

Full Name		Surgery Stamp
Address		
Post Code		

Email address

### MEDICAL DECLARATION

Applicant / Driver Name:

The above named person is registered with this surgery as a patient. Yes  No

I have seen a summary of the above named person's medical records. Yes  No

I consider that the above named person meets the Group 2 medical standards of fitness to drive, as set out in the latest editions of the DVLA publication for Medical Practitioners 'At a Glance Guidance for Current Medical Standards of Fitness to Drive' and The Medical Commission's Accident Prevention publication 'Medical Aspects of Fitness to Drive.' Yes  No

Signature of Medical Practitioner

Date







### 3 Cardiac

#### a Coronary artery disease

Is there a history or evidence of coronary artery disease? Yes No

**If no, go to section 3b, Cardiac arrhythmia**

If yes, please answer all questions below.

1. Has the applicant ever had an episode of angina? Yes No

If yes, please give the date of the last known attack.

2. Acute coronary syndrome including myocardial infarction? Yes No

If yes, please give date.

3. Coronary angioplasty (PCI)? Yes No

If yes, please give date of most recent intervention.

4. Coronary artery bypass graft surgery? Yes No

If yes, please give date.

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? Please give details below. Yes No

#### b Cardiac arrhythmia

Is there a history or evidence of cardiac arrhythmia? Yes No

**If no, go to section 3c, Peripheral arterial disease**

If yes, please answer all questions below.

1. Has there been a significant disturbance of cardiac rhythm causing/likely to cause incapacity in the last 5 years? Yes No

2. Has the arrhythmia been controlled satisfactorily for at least 3 months? Yes No

3. Has an ICD (Implanted Cardiac Defibrillator) or biventricular pacemaker with defibrillator/ cardiac resynchronisation therapy defibrillator (CRT-D type) been implanted? Yes No

4. Has a pacemaker or a biventricular pacemaker/ cardiac resynchronisation therapy pacemaker (CRT-P type) been implanted? Yes No

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?

#### c Peripheral arterial disease (excluding Buerger's disease) aortic aneurysm/dissection

Is there a history or evidence of peripheral arterial disease (excluding Buerger's disease), aortic aneurysm or dissection? Yes No

**If no, go to section 3d, Valvular/congenital heart disease**

If yes, please answer all questions below.

1. Peripheral arterial disease? (excluding Buerger's disease) Yes No

2. Does the applicant have claudication? Yes No  
   
 If yes, would the applicant be able to undertake 9 minutes of the standard Bruce Protocol ETT?

3. Aortic aneurysm? Yes No  
 If yes:

(a) Site of aneurysm: Thoracic    
 Abdominal

(b) Has it been repaired successfully?

(c) Please provide latest transverse aortic diameter measurement and date obtained using measurement and date boxes.

cm

4. (a) Dissection of aorta? Yes No

(b) If yes, has the dissection been successfully repaired?

If yes to 4a, please provide copies of all reports including those dealing with any surgical treatment.

5. Is there a history of Marfan's disease? Yes No

(a) If yes, are there any associated risk factors\*?

\*risk factors include –

- family history of aortic dissection
- greater than 3mm per year increase than aneurysm diameter
- pregnancy

#### d Valvular/congenital heart disease

Is there a history or evidence of valvular or congenital heart disease? Yes No

**If no, go to section 3e, Cardiac other**

If yes, please answer all questions below.

1. Is there a history of congenital heart disease? Yes No

2. Is there a history of heart valve disease? Yes No

(a) If yes, are they symptomatic?

3. Is there a history of aortic stenosis? Yes No  
 If yes, please provide relevant reports (including echocardiogram).

4. Has there been any progression (either clinically or on scans etc) since the last licence application? Yes No

Applicant's full name

Date of birth

## e Cardiac other

Is there a history or evidence of heart failure? Yes No

If no, go to section 3f, Cardiac channelopathies

If yes, please answer all questions below.

1. Please provide the NYHA class, if known.

2. Established cardiomyopathy? Yes No

If yes, please give details in section 9, page 6.

3. Has a left ventricular assist device (LVAD) or other cardiac assist device been implanted? Yes No

4. A heart or heart/lung transplant? Yes No

5. Evidence or history of pulmonary arterial hypertension? Yes No

## f Cardiac channelopathies

Is there a history or evidence of the following conditions? Yes No

If no, go to section 3g, Blood pressure

1. Brugada syndrome? Yes No

2. Long QT syndrome? Yes No    
If yes to either, please give details in section 9, page 6.

## g 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 in the box provided.

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.

<input type="text"/>	/	<input type="text"/>
<input type="text"/>	/	<input type="text"/>
<input type="text"/>	/	<input type="text"/>

D	D	M	M	Y	Y
D	D	M	M	Y	Y
D	D	M	M	Y	Y

## h Cardiac investigations

Have any cardiac investigations been undertaken or planned? Yes No

If no, go to section 4, Psychiatric illness

If yes, please answer questions 1 to 5.

1. Is there a history of the following: Yes No

(a) left bundle branch block (LBBB)?

(b) right bundle branch block (RBBB)?

(c) paced rhythm?

If yes to (a), (b) or (c), please give details in section 9, page 6.

Note: If yes to questions 2 to 5, please give dates in the boxes provided, give details in section 9, page 6.

2. Has an exercise ECG been undertaken (or planned)? Yes No

3. Has an echocardiogram been undertaken (or planned)? Yes No

(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)? Yes No

5. Has a myocardial perfusion scan, stress echo study or cardiac MRI been undertaken (or planned)? Yes No

## 4 Psychiatric illness

Is there any significant mental illness or cognitive impairment likely to affect safe driving? Yes No

If no, go to section 5, Substance misuse

If yes, please answer all questions below.

1. Significant psychiatric disorder within the past 6 months? If yes, please confirm condition. Yes No

2. Psychosis or hypomania/mania within the past 12 months, including psychotic depression? Yes No

3. (a) Dementia or cognitive impairment? Yes No    
(b) Are there concerns which have resulted in ongoing investigations for such possible diagnoses?

## 5 Substance misuse

Is there a history of drug/alcohol misuse or dependence? Yes No

If no, go to section 6, Sleep disorders

If yes, please answer all questions below.

1. Is there a history of an alcohol use disorder (sufficient to cause significant physical, mental or social consequences) in the past 10 years? Yes No

2. If there is a history of an alcohol use disorder, has this been associated with any of the following features which indicate a physiological dependence on alcohol: Yes No

(a) Required medical assisted withdrawal?

Date treatment ended:

(b) Alcohol withdrawal seizure?

Date of last event:

3. Based on their clinical record and/or account of drinking provided to you, is their alcohol consumption:

(a) Abstinent? Yes  No  Don't know

If yes, for how long:

(b) Controlled? Yes  No  Don't know

If yes, for how long:

4. Use of illegal drugs or other substances, or misuse of prescription medication in the last 6 years? Yes No

(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

Applicant's full name

Date of birth

## 6 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 7, Other medical conditions.**

If yes, please give diagnosis and answer all questions below.

- 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 page 6, Further details.

- b) Please answer questions (i) to (iv) for **all** sleep conditions.

(i) Date of diagnosis:         Yes No

(ii) Is it controlled successfully?

(iii) Is applicant compliant with treatment?

(iv) Date of last review.

## 7 Other medical conditions

1. Is there a history or evidence of narcolepsy? Yes No

2. Is there any impairment resulting from either a physical or non-physical medical condition which is likely to affect the ability to control a vehicle? Yes No

If yes, please provide information in section 9, page 6.

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. Does the applicant have a history of liver disease of any origin? Yes No  
   
 If yes, is this the result of alcohol misuse?    
 If yes, please give details in section 9, page 6.

6. Is there a history of renal failure? Yes No  
   
 If yes, please give details in section 9, page 6.

7. Does the applicant have severe symptomatic respiratory disease causing chronic hypoxia? Yes No

8. Does the applicant have any other medical condition that could affect safe driving? Yes No  
   
 If yes, please provide details in section 9, page 6.

## 8 Medication

Is the applicant currently prescribed any of the following medication:

- |                                 | Yes                      | No                       |
|---------------------------------|--------------------------|--------------------------|
| (a) Anti-seizure?               | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Clozapine?                  | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) Sulphonylurea or a Glinide? | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) Insulin?                    | <input type="checkbox"/> | <input type="checkbox"/> |

## 9 Further details

Do not send any notes not related to fitness to drive.

Use the space below to provide any additional information.

Applicant's full name

Date of birth



## The applicant must fill in this page

### Applicant's declaration

You **must** fill in this section and **must not** alter it in any way.

Please read the following important information carefully then sign to confirm the statements below.

#### Important information about fitness to drive

As part of the enquiries into your fitness to drive, we (DVLA) may need you to have a medical examination and/or some form of practical assessment. If we do, the individuals involved in these will need your background medical details to carry out an appropriate assessment.

These individuals may include doctors, orthoptists at eye clinics or paramedical staff at a driving assessment centre. We will only share information relevant to the medical assessment of your fitness to drive.

Also, where the circumstances of your case appear to suggest the need for this, the relevant medical information may need to be considered by one or more of the members of the Secretary of State's Honorary Medical Advisory Panels. The membership of these Panels conforms strictly to the principle of confidentiality.

For information about how we process your data, your rights and who to contact, see our privacy notice at [www.gov.uk/dvla/privacy-policy](http://www.gov.uk/dvla/privacy-policy)

#### Declaration

I authorise my doctor, specialist or appropriate healthcare professional to disclose medical information or reports about my health condition to the DVLA, on behalf of the Secretary of State for Transport, that is relevant to my fitness to drive.

I understand that the doctor that I authorise, may pass this authorisation to another registered healthcare professional, who will be able to provide information about my medical condition that is relevant to my fitness to drive.

I understand that the Secretary of State may disclose such relevant medical information as is necessary to the investigation of my fitness to drive to doctors and other healthcare professionals such as orthoptists, paramedical staff and the Secretary of State for Transport's Honorary Medical Advisory panel members.

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.

Name

Signature

Date

**I authorise the Secretary of State to correspond with medical professionals via electronic channels (email)**

Yes  No

#### Checklist

- Have you signed and dated the declaration? **Yes**
- Have you checked that the optician, optometrist or doctor has filled in all parts of the report and all relevant hospital notes have been enclosed? **Yes**

#### Important

**This report is valid for 4 months from the date the doctor, optician or optometrist signs it.**

**Please return it together with your application form.**