

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

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 any illness that may cause significant fatigue or cachexia that affects safe driving? Yes No

4. 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.

5. Is there a history of renal failure? Yes No

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

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

7. 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

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.