Reading BOROUGH COUNCIL

Medical Examination Report

to be completed by the Doctor (please use black ink)
Please answer all questions

Please give patient's weight..... Kg/st and height.....ft/cms

Please give details of smoking habits, if any .....

Please give number of alcohol units taken each week .....

1. Vision Please refer to section C3 of the guidance notes

1. Is the visual acuity as measured by the Snellen chart **at least** 6/9 in the better eye and **at least** 6/12 in the other? (corrective lenses may be worn) **Yes☐** **No☐**

2. Do corrective lenses have to be worn to achieve this standard? **Yes☐** **No☐**

   (a) If **Yes**, is the **uncorrected** acuity **at least** 3/60 in the **right** eye? **Yes☐** **No☐**

   (b) is the **uncorrected** acuity **at least** 3/60 in the **left** eye? **Yes☐** **No☐**

   (c) is the correction well tolerated? **Yes☐** **No☐**

3. Please state the visual acuities for all applicants:

2. Nervous System

1. Has the applicant had any form of Epileptic Attack? **Yes☐** **No☐**
   (a) If **Yes,** please give date of last attack.

   (b) If treated, please give date when treatment ceased.

2. Is there a history of blackout or impaired consciousness within the last 5 years? **Yes☐** **No☐**

3. Is there a history of stroke or TIA within the past 5 years?
   If **Yes**, please give date(s) and details in **Section 7.** **Yes☐** **No☐**

4. Is there a history of sudden disabling dizziness/vertigo within the last 1 year with a liability to recur? **Yes☐** **No☐**

5. Does the patient have a pathological sleep disorder? **Yes☐** **No☐**
   If **Yes**, has it been controlled successfully? Please give details in **Section 7.**

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6. Is there a history of chronic and/or progressive neurological disorder?
If **Yes,** please give date(s) and details in **Section 7.** **Yes☐** **No☐**

7. Is there a history of brain surgery?
If **Yes**, please give date(s) and details in **Section 7.** **Yes☐** **No☐**

8. Is there a history of serious head injury?
If **Yes**, please give date(s) and details in **Section 7.** **Yes☐** **No☐**

9. Is there a history of brain tumour either, benign or malignant, primary or secondary?
If **Yes,** please give date(s) and details in **Section 7.** **Yes☐** **No☐**

3. Diabetes Mellitus

1. Does the applicant have Diabetes Mellitus? **Yes☐** **No☐**
If **Yes**, please answer the following questions.
If **No**, proceed to **Section 4.**

2. Is the Diabetes managed by:-
(a) Insulin? **Yes☐** **No☐**
(b) If **Yes**, date started on insulin.

(c) Oral Hypoglycaemic agents and diet? **Yes☐** **No☐**
(d) Diet only? **Yes☐** **No☐**

3. Is the Diabetic control generally satisfactory? **Yes☐** **No☐**

4. Is there evidence of:-
(a) Loss of visual field? **Yes☐** **No☐**
(b) Has there been bilateral laser treatment? If **Yes**, please give date.

(c) Severe peripheral neuropathy? **Yes☐** **No☐**
(d) Significant impairment of limb function or joint position sense? **Yes☐** **No☐**
(e) Significant episodes of Hypoglycaemia? **Yes☐** **No☐**
(f) Complete loss of warning symptoms of Hypoglycaemia? **Yes☐** **No☐**

If yes, to any of the above, please give details in Section 7.

4. Psychiatric Illness

1. Has the applicant suffered from or required treatment for a **psychotic illness** in the last 3 years? **Yes☐** **No☐**
If **Yes**, please give date(s) and details in **Section 7.**

2. Has the applicant required treatment for any other significant psychiatric disorder within the past 6 months? **Yes☐** **No☐**
If **Yes**, please give date(s) and details in **Section 7.**

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3. Is there any evidence of Dementia or Cognitive Impairment? **Yes☐** **No☐**
If **Yes**, please give details in **Section 7.**

4. Is there any history or evidence of alcohol misuse or alcohol dependency in the past 3 years? **Yes☐** **No☐**

5. Is there a history or evidence of persistent drug or substance misuse or dependency in the past 3 years? **Yes☐** **No☐**
If **Yes**, to questions 4 or 5, please give details in **Section 7.**

5. General

1. Has the applicant **currently** a significant disability of the spine or limbs which is likely to impair control of the vehicle, or prevent carrying a reasonable amount of luggage? **Yes☐** **No☐**
If **Yes**, please give details in **Section 7.**

2. Is there a history of Bronchogenic Carcinoma or other malignant tumour, for example, Malignant Melanoma, with a significant liability to metastasise cerebrally? **Yes☐** **No☐**
If **Yes**, please give details and diagnosis and state whether there is current evidence of dissemination.

3. Is the applicant profoundly deaf? **Yes☐** **No☐**
If **Yes**, could this be overcome by any means to allow a telephone to be used in an emergency?

4 Does the applicant have a medical condition, which is aggravated by contact with dogs, or is allergic, or have a chronic phobia to dogs? (Taxi or Private Hire Drivers may be required to carry assistance dogs in their vehicle). **Yes☐** **No☐**
If **Yes**, please give details in **Section 7.**

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6. Cardiac

A. Coronary Artery Disease

1. Myocardial Infarction? **Yes☐** **No☐**
If **Yes,** please give date(s).

2. Coronary Artery by-pass graft? **Yes☐** **No☐**
If **Yes**, please give date(s).

3. Coronary Angioplasty? **Yes☐** **No☐**
If **Yes**, please give date(s).

4. Any other Coronary Artery procedure? **Yes☐** **No☐**
If **Yes**, please give details in **Section 7.**

5. Has the applicant suffered from Angina? **Yes☐** **No☐**
If **Yes,** please give date of the last attack.

6. Has the applicant suffered from Heart Failure? **Yes☐** **No☐**
If **Yes,** is the applicant **still** suffering from Heart Failure or only remains controlled by the use of medication?

7. Has a resting ECG been undertaken? **Yes☐** **No☐**
If **No**, proceed to question 8.
(a) If **Yes**, please give date.

(b) Does it show Pathological Q Waves? **Yes☐** **No☐**
(c) Does it show Left Bundle Branch Block? **Yes☐** **No☐**

8. Has an exercise ECG been undertaken (or planned?) **Yes☐** **No☐**
If **Yes**, please give date.

And give details in **Section 7.**

9. Has an Angiogram been undertaken (or planned?) **Yes☐** **No☐**
If **Yes**, please give date.

And give details in **Section 7.**

B. Cardiac Arrhythmia

1. Has the applicant had a significant documented disturbance of Cardiac Rhythm within the past 5 years? If **Yes**, please give details in **Section 7**
Yes☐ **No☐**

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2. Has the Arrhythmia (or its medication) caused symptoms of sudden dizziness or impairment of consciousness or any symptoms likely to distract attentions during driving within the past 2 years? **Yes☐ No☐**

3. Has Echocardiography been undertaken? If **Yes**, please give details in **Section 7** **Yes☐ No☐**

4. Has an exercise test been undertaken? If **Yes,** please give details in **Section 7** **Yes☐ No☐**

5. Has a Cardiac Defibrillator or Antiventricular Tachycardia device been implanted? **Yes☐ No☐**

6. Has a Pacemaker been implanted? If No, proceed to Section C overleaf. **Yes☐ No☐**

(a) If **Yes**, was it implanted to prevent Bradycardia? **Yes☐ No☐**
(b) Is the applicant continuing to suffer from sudden and/or disabling symptoms? **Yes☐ No☐**
(c) Does the applicant attend a Pacemaker Clinic regularly? **Yes☐ No☐**

C. Other Vascular Disorders

1. Is there a history of Aortic Aneurysm (Thoracic or Abdominal) With a transverse diameter of 5cms or more? **Yes☐ No☐**
If **No,** proceed to **Section D.**
If **Yes**, has the aneurysm been successfully repaired? **Yes☐ No☐**

2. Has there been dissection of the Aorta? **Yes☐ No☐**

3. Is there a history or evidence of Peripheral Vascular Disease? **Yes☐ No☐**
If **Yes**, please give details in **Section 7.**

D. Blood pressure

1. Does the patient suffer from Hypertension requiring treatment? **Yes☐ No☐**

(a) If **Yes**, is the Systolic pressure consistently greater than 180? **Yes☐ No☐**
(b) Is the Diastolic consistently greater than 100? **Yes☐ No☐**
(c) Does the Hypertensive treatment cause any side effects likely to affect driving ability? **Yes☐ No☐**

2. Is it possible that your patient suffers from Hypertension but as yet the diagnosis is not definitely established? **Yes☐ No☐**

If **Yes**, please supply last 3 readings and dates obtained.

E. Valvular Heart Disease

1. Is there a history of Acquired Valvular Heart Disease (with or without surgery?) **Yes☐ No☐**

If **No,** proceed to **Section F.**

2. Is there any history of Embolism? (Not Pulmonary Embolism)?
If **Yes**, please give details in **Section 7**. **Yes☐ No☐**

3. Is there persistent Dilatation or Hypertrophy of either Ventricle? **Yes☐ No☐**
If **Yes**, please give details in **Section 7.**

F. Cardiomyopathy

1. Is there established Cardiomyopathy? **Yes☐ No☐**

2. Has there been a heart or heart/lung transplant? **Yes☐ No☐**
If **Yes**, please give details in **Section 7.**

G. Congenital Heart Disorders

1. Is there a Congenital Heart Disorder? **Yes☐ No☐**
If **Yes**, please give details in **Section 7.**
(b) If **Yes**, is it **currently** regarded as minor? **Yes☐ No☐**

H. Specialist Cardiac Clinics

Is the patient in the care of Specialist Cardiac Clinic? **Yes☐ No☐**
If **Yes**, please give details in **Section 7.**

Please remember to complete SECTION 7 if you have answered YES to any questions.

7. Details of Medical Conditions

Please forward copies of all hospital notes if available

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8. Applicant's Consent and Declaration

Consent and Declaration

This section **must** be completed and must **not** be altered in any way.

Please sign statements below.

I authorise my Doctor(s) and Specialist(s) to release reports to Reading Borough Council's Medical Adviser about my medical condition.

I authorise Reading Borough Council's Medical Adviser to divulge relevant medical information about me to Doctors or Paramedical staff as necessary in the course of medical enquiry into my fitness to drive.

I declare that I have checked the details I have given on the enclosed questionnaire and that to the best of my knowledge they are correct.

Signature: ……..

Date: ……

I authorise Reading Borough Council's Medical Adviser to release medical information to my Doctors and/or Specialists about the outcome of my case. (This is to enable your Doctor to advise you about fitness to drive).

Signature: ……..

Date: ……

Note about consent

You will see that we have asked for your consent, not only for the release of medical reports from your doctors, but also that we might in our turn very occasionally release information to Doctors or Paramedical staff, either because we wish you to be examined, and the doctors need to know the medical details, or because we require further information. You need to understand quite clearly how we define Paramedical Staff. Many patients need to be assessed in Driving Assessment Centres who employ Occupational Therapists, Physiotherapists and experienced Driving Instructors, all of whom need to understand about a patient's medical condition in order to produce a helpful report. Only occasionally do we need to do this and it may well not apply in your case. We never, under any circumstances, release information which is not relevant to fitness to drive, nor would we expect to receive this from your Doctors.

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9. Applicant's Details

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

Your name		Date of Birth	
Your Address		Telephone - Home	
		Daytime/work	

About your Consultant/Specialist or previous *(If applicable)*

GP/Group name	Consultants name
Address	Address
Telephone	Telephone

Date when you were first licensed to drive a Hackney Carriage or Private Hire/School Transport Vehicle	
Date last medical undertaken	

10 Medical Practitioner Details

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

Surgery Stamp

Name
Address

I CERTIFY that I have this day examined the applicant, who has signed this form in my presence.

Does the applicant in your opinion meet the standard of medical fitness required for a Group 2 driver, as set out in the current edition of "Medical Aspects of Fitness to Drive" and DVLA's "At a Glance"? **Yes☐ No☐**

Signature of Medical Practitioner …….
Date …….

Please make sure that you have printed your name and date of birth on each page before <u>sending this form with your application to Licensing, Reading Borough Council, Civic Offices, Bridge Street, Reading, RG1 2LU.</u> Alternatively you may scan and e-mail the attached to licensing@reading.gov.uk