Type of application applied for (tick as appropriate)

Taxi ☐ **or Private Hire** ☐

Medical Assessment for Taxi or Private Hire Car Drivers Applicants

ONLY THIS PAGE IS TO BE RETURNED TO ANGUS COUNCIL

Applicant's Details

Surname		Date of Birth	
Forename		Home Tel. No	
Address		Work Tel. No	
Postcode			
Own GP			

Applicant's Consent and Declaration

I declare that I have given the examining doctor all relevant information relating to my medical history to enable him to assess my suitability for driving a taxi or a private hire vehicle.

Signed _____ Date_____

Examining Doctor – Please fully complete as appropriate

N.B. When assessing the applicant's fitness to drive you should make your assessment based on DVLA Group 2 standards.

I have today examined the above named person and am

satisfied * / not satisfied * *delete as appropriate

that he/she is medically and physically fit in terms of DVLA Group 2 standards to drive a taxi or private hire car.

I have*/have not* conducted a vision test *delete as appropriate

Signed _____ Date_____

Doctor _____

Address _____

_____

_____

THIS PART TO BE RETAINED BY EXAMINING DOCTOR OR APPLICANT

Medical Examination Report

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

Please answer all questions

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 sample taken, 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	

1 Vision

Please tick ✓ the appropriate box(es)		**YES**	**NO**
1.	Is the visual acuity **at least** 6/7.5 in the better eye and at least 6/60 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?	☐	☐

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

		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)		
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**		
		YES	**NO**
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

		YES	NO
1.	**Does the applicant have diabetes mellitus?**		
	If NO, please proceed to **Section 4.**		
	If **YES**, please answer the following questions.		
2.	Is the diabetes managed by:-		
	(a) Insulin?		
	If Yes, please give date started on insulin (D D M M Y Y)		
	(b) Oral hypoglycaemic agents and diet?		
	(c) Diet only?		
3.	Does the patient 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 (D D M M Y Y)		
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

Is there a history of, or evidence of any of the conditions listed at 1-6 below? YES ☐ NO ☐

If NO, please go to **Section 5.**

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.	**YES**	**NO**
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	☐	☐

5 Cardiac

Please follow the instructions in all Sections (5A-5G) giving details as required at Section 7.

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

5A Coronary Artery Disease

Is there a history of, or evidence of, coronary artery disease? YES ☐ NO ☐

If NO, proceed to **Section 5B**

If **YES**, please answer all questions below and give details at **Section 7** of the form.

1. Myocardial Infarction? ☐ ☐

If **Yes**, please give date(s) D D M M Y Y

2. Coronary artery by-pass graft? ☐ ☐

If **Yes**, please give date(s) D D M M Y Y

3. Coronary Angioplasty (with or without stent)? ☐ ☐

If **Yes**, please give date(s) D D M M Y Y

4. Has the applicant suffered from Angina? ☐ ☐

If **Yes**, please give the date of the last attack D D M M Y Y

Please proceed to next Section 5B

5B Cardiac Arrhythmia

	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.

		YES	NO
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 been implanted?		
4.	Has a pacemaker been implanted?		
	If **YES**:-		
	(a) Has the pacemaker been implanted for at least 6 weeks		
	(b) Since implantation, is the patient now symptom free from this condition?		
	(c) Does the applicant attend a pacemaker clinic regularly?		

Please proceed to next Section 5C

5C Peripheral Arterial Disease

		YES	NO
1.	Is there a history or evidence of ANY of the following:		

If **YES** please **tick** ✓ ALL relevant boxes below, and give details at **Section 7** of the form.

		YES	NO
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 5 cms:		
DISSECTION OF THE AORTA, IF YES:			
a	Has it been repaired successfully:		

Please proceed to next Section 5D

5D Valvular/Congenital Heart Disease

	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.

		YES	NO
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

		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

This section must be completed for all applicants

		YES	NO
1.	Has a resting ECG been undertaken?		
	If **YES**, does it show:-		
(a)	pathological Q waves?		
(b)	left bundle branch block?		
2.	Has an exercise ECG been undertaken or planned?		
	If **Yes**, please give date D D M M Y Y and give details in **Section 7**		
3.	Has an echocardiogram been undertaken (or planned)?		
	If **Yes**, please give date D D M M Y Y and give details in **Section 7**		
4.	Has a coronary angiogram been undertaken (or planned)?		
	If **Yes**, please give date D D M M Y Y and give details in **Section 7**		
5.	Has a 24 hour ECG tape been undertaken (or planned)?		
	If **Yes**, please give date D D M M Y Y and give details in **Section 7**		
6.	Has a myocardial perfusion imaging scan been undertaken (or planned)?		
	If **Yes**, please give date D D M M Y Y and give details in **Section 7**		

Please proceed to Section 5G

5G Blood Pressure

This section must be completed for all applicants

		YES	NO
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

6 General

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

		YES	NO
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.		
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**, has it been controlled successfully?		
6.	Is there any other **Medical Condition**, causing excessive daytime sleepiness?		
6a.	If **YES**, please give full details below.		
7.	Does the applicant have severe symptomatic respiratory disease causing chronic hypoxia?		
8.	Does any medication currently taken cause the applicant side effects which impair his/her safe driving?		

7	**Additional Information**

Please provide any other required details in this section. Continue on a separate sheet if necessary.

ONLY TO BE COMPLETED IF DOCTOR HAS NOT CONDUCTED A VISION TEST

Type of application applied for (tick as appropriate)

Taxi ☐ **or Private Hire** ☐

Angus Council

Vision Assessment for Taxi or Private Hire Car Drivers Applicants

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Applicant's Details

Surname		Date of Birth	
Forename		Home Tel. No	
Address		Work Tel. No	
Postcode			
Own GP			

Applicant's Consent and Declaration

I declare that I have given the examining optician all relevant information relating to my medical history to enable him to assess my suitability for driving a taxi or a private hire vehicle.

Signed _____ Date_____

Examining Optician – Please fully complete as appropriate

I have today examined the above named person and am

satisfied * / not satisfied * *delete as appropriate

that his/her vision permits him/her in terms of DVLA Group 2 standards to drive a taxi or private hire car.

Signed _____ Date_____

Optician _____

Address _____

_____

_____

THIS PART TO BE RETAINED BY EXAMINING DOCTOR OR APPLICANT

Examination Report

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

Please answer all questions

1 Vision

Please tick ✓ the appropriate box(es)		**YES**	**NO**
1.	Is the visual acuity **at least** 6/7.5 in the better eye and at least 6/60 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?		

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 answer question **7** and enclose any relevant visual field charts or hospital letters.

7 Additional Information

Please provide any other required details in this section. Continue on a separate sheet if necessary.