



South Cambridgeshire District Council Hackney Carriage and Private Hire Driver Medical Certificate

Patient's name:		Surgery stamp
Patient's address:		

You are 'Assessing fitness to drive' at DVLA Group 2 Standard. All practitioners should have regard to the DVLA's guidance for medical professionals. See <https://www.gov.uk/government/collections/assessing-fitness-to-drive-guide-for-medical-professionals>

Confirmation of medical (please tick)

At the time of the physical examination, and the completion of this medical form, I had access to the individual's full medical records	Yes	
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Please note – South Cambridgeshire District Council will not accept any medical conducted in the absence of the individual's full medical history.

Outcome of medical (please tick)

In conjunction with the DVLA guidance, examination findings and the information given, the above named is:

Medically fit I see no medical reason why this person is unfit to drive hackney carriage or private hire vehicles		Medically unfit to drive hackney carriage or private hire vehicles	
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Declaration

I confirm that this certificate was completed by me at the physical examination, and that I am currently a doctor who holds a current licence to practice medicine registered with the General Medical Council

Name of assessor conducting examination	
Signature	
Date	
GMC number	

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"/>							

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: Yes No Don't know

(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

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.