ST HELENS
BOROUGH COUNCIL

GROUP 2 MEDICAL ASSESSMENT

ASSOCIATED WITH AN APPLICATION FOR A LICENCE TO DRIVE A HACKNEY CARRIAGE OR PRIVATE HIRE VEHICLE

IMPORTANT: ASSESSMENTS MUST NOT TAKE PLACE MORE THAN <u>TWO CALENDAR MONTHS</u> BEFORE THE DATE A LICENCE IS GRANTED OR RENEWED.

Applicant's Details: (to be completed in the presence of the GP or Doctor carrying out the examination)

Full name: _____ Date of Birth: _____ Age: _____

Address: _____ Postcode: _____

I hereby authorise my doctor(s) and specialists to release reports/medical information to the Medical Practitioner, should they require further information about condition(s) relevant to my fitness to drive to group 2 standard.

Signature of Applicant	Signed:	Date:

The applicant has provided me the following form of identification:

Driving Licence ❑ Passport ❑ Birth Certificate ❑ HM Forces ID Card ❑

You are Assessing Fitness to Drive at DVLA Group 2 Standard, a guidance for medical professionals is available online at https://www.gov.uk/guidance/assessing-fitness-to-drive-a-guide-for-medical-professionals This medical must be completed in person and not remotely.

Medical certification frequency requirement

- A new certificate must be produced every 5 years after the applicant's 45th birthday.
- Once the age of 65 is reached, a medical certificate must be produced every year.

Earlier medical certification frequency requirement

The above medical certification frequency is not sufficient: ❑ (tick box **if applicable**) and I recommend that the applicant is examined no later than: (insert date) _____

❑ I certify that I have on this day examined the applicant, who signed this form in my physical presence and showed a form of identification as indicated above and they have provided me with their full medical records obtained within the last month for which I have reviewed to ascertain their medical fitness to Group 2 Standards and I declare that they meet the below:

Medically Fit ❑ **Medically Unfit** ❑ to drive a hackney carriage or private hire vehicle.

Name of GMC registered Medical Practitioner _____

Signature of GMC registered Medical Practitioner _____ Date _____

GMC Reference Number							

Please add address and phone number
or Medical Practice Address Stamp
No disclaimers are acceptable.

PLEASE ENSURE YOU COMPLETE AND SIGN THE ADDITONAL INFORMATION PAGE OVERLEAF

ADDITIONAL INFORMATION

Please note any relevant medical information about the applicant here that would normally be noted in section 9 of the standard Group 2 Medical form.

GP Signature _____ Date _____

Section 1

Vision Assessment – to be completed by the GP or Optician/Optometrist

Please see the current DVLA guidance so that you can decide whether you are able to fully complete the vision assessment at www.gov.uk/current-medical-guidelines-dvla-guidance-for-professionals

1	Please confirm the scale you are using to express the driver's visual acuities: ☐ Snellen ☐ Snellen expressed as a decimal ☐ LogMAR				
2	The visual acuity standard for Group 2 driving is at least 6/7.5 in one eye and at least 6/60 in the other.				
	a	Please provide uncorrected visual acuities for each eye. Snellen readings with a plus (+) or minus (-) are not acceptable. If 6/7.5, 6/60 standard is not met, the applicant may need further assessment by an optician.	Right	Left	
	b	Are corrective lenses worn for driving? If **NO**, go to **Question 3**.		**Yes** ☐	**No** ☐
		If **YES**, please provide the visual acuities using the correction worn for driving. Snellen readings with a plus (+) or minus (-) are not acceptable. If 6/7.5, 6/60 standard is not met, the applicant may need further assessment by an optician.	Right	Left	
	c	What kind of corrective lenses are worn to meet this standard? ☐ Glasses ☐ Contact lenses ☐ Both			
	d	If glasses are worn for driving, is the corrective power greater than plus (+) 8 dioptres in any meridian of either lens?		☐	☐
	e	If correction is worn for driving, is it well tolerated? If **NO**, please give full details in **Question 8**.		☐	☐
3	Is there a known visual field defect?			☐	☐
4	Are there any medical conditions which might result in a visual field defect? If **YES**, please give full details of the condition in **Question 8**.			☐	☐
	a	If yes, has a visual field defect been excluded?		☐	☐
5	Is there diplopia?			☐	☐
	a	Is it controlled?		☐	☐
	b	Please indicate below and give full details in **Question 8**. ☐ Patch or glasses with frosted glass ☐ Glasses with/ without prism ☐ Other			
6	Does the applicant report symptoms of any of the following that impairs their ability to drive? If **YES**, please give full details in **Question 8**.			☐	☐
	a	Intolerance to glare (causing incapacity rather than discomfort)		☐	☐
	b	Impaired contrast sensitivity		☐	☐
	c	Impaired twilight vision		☐	☐

GP Signature _____ Date _____

7	Does the applicant have any other ophthalmic condition affecting their visual acuity or visual field? If **YES**, please give full details in **Question 8**.	☐	☐
8	Details or additional information		

Name of examining doctor, optician or optometrist undertaking vision assessment.

Name: Address:

Contact telephone number:

GP Signature _____ Date _____

Section 2

NEUROLOGICAL DISORDERS

							Yes	No
	Is there any history of, or evidence of, **any** neurological disorder? If **No,** go to **section 3**						☐	☐
1	Has the applicant had any form of seizure? If **YES,** please answer questions a – f below.						☐	☐
	a	Has the applicant had more than one seizure episode?					☐	☐
	b	Please give date of first and last attack:	*First attack*	DD MM YY	*Last attack*	DD MM YY		
	c	Is the applicant currently on anti-seizure medication? If **YES,** please give details of current medication in the **Additional Information** section**.**					☐	☐
	d	If no longer treated, please give date when treatment ended.				DD MM YY		
	e	Has the applicant had a brain scan? If **YES,** please provide date and details in the **Additional Information** section.					☐	☐
2	Has the applicant experienced any dissociative/ functional seizures?						☐	☐
	a	If **YES** to question 2, please give date of most recent episode.				DD MM YY		
	b	If **YES** to question 2, have any of these episodes occurred or are they considered likely to occur whilst driving?					☐	☐
3	Store or TIA? If **YES** please give date: DD MM YY						☐	☐
	a	Has there been a **FULL** recovery?					☐	☐
	b	Has a carotid ultrasound been undertaken?					☐	☐
	c	If **YES,** was the carotid artery stenosis >50% in either carotid artery?					☐	☐
	d	Is there a history of multiple strokes/ TIA'?					☐	☐
4	Sudden and disabling dizziness or vertigo within the last year with a liability to recur?						☐	☐
5	Subarachnoid haemorrhage (non-traumatic)?						☐	☐
6	Significant head injury within the last 10 years?						☐	☐
7	Any form of brain tumour?						☐	☐
8	Other intracranial pathology?						☐	☐
9	Chronic neurological disorder(s)?						☐	☐
10	Parkinson's disease?						☐	☐
11	Blackout, impaired consciousness or loss of awareness within the last 5 years?						☐	☐

If **YES** to any of the above, please give details in the **Additional Information** section.

GP Signature _____ Date _____

Section 3

DIABETES MELLITUS

			Yes ☐	No ☐
Does the applicant have diabetes mellitus? If **NO** please go to Section 4. If **YES** please answer the following questions.				
1	Is the diabetes managed by:			
	a	Insulin? If **YES,** please give date started on insulin: DD MM YY	☐	☐
	b	If **YES** to question 1a, are there at least 4 continuous weeks of glucose readings stored on a memory meter or meters? If **NO**, please give details in the **Additional Information** section.	☐	☐
	c	Other injectable treatments?	☐	☐
	d	A Sulphonylurea or a Glinide?	☐	☐
	e	Oral hypoglycaemic agents and diet?	☐	☐
	f	Diet only?	☐	☐
	If **YES** to any of (a) – (e) above, please give details in the **Additional Information** section.			
2	a	Does the applicant monitor their glucose level using continuous glucose monitoring (CGM)?	☐	☐
	b	If YES, if the continuous glucose monitoring (CGM) device approved for non-adjunctive use?	☐	☐
	c	Does the applicant carry a finger prick monitoring device?	☐	☐
	d	Does the applicant test glucose at least twice every day?	☐	☐
	e	Does the applicant test at times relevant to driving? (Within 2 hours of starting their first journey of the day and continuing to check at least every 2 hours during their journey. There must be no more than 2 hours between glucose checks at any time during their journey).	☐	☐
	f	Does the applicant keep fast acting carbohydrate within easy reach when driving?	☐	☐
	g	Does the applicant have a clear understanding of diabetes and the necessary precautions for safe driving?	☐	☐
3	a	Has the applicant ever had a hypoglycaemic episode?	☐	☐
	b	Is there full awareness of hypoglycaemia?	☐	☐
4	Is there a history of hypoglycaemia in the last 12 months requiring the assistance of another person?		☐	☐
If **YES** to any of the above, please give details in the **Additional Information** section.				
5	Has there been any laser treatment or intra-vitreal for retinopathy? If **YES** please give most recent date of treatment: DD MM YY		☐	☐

GP Signature _____ Date _____

Section 4

CARDIAC

4A CORONARY ARTERY DISEASE

		Yes ☐	No ☐
	Is there a history of, or evidence of, Coronary Artery Disease? If **NO,** please go to Section 4B. If **YES,** please answer all questions below and give details in the **Additional Information** section.		
1	Has the applicant ever had an episode of angina? If **YES** please give the date of the last known attack: DD MM YY	☐	☐
2	Acute coronary syndrome including myocardial infarction? If **YES** please give date(s): DD MM YY	☐	☐
3	Coronary Angioplasty (PCI)? If **YES** please give date of most recent intervention: DD MM YY	☐	☐
4	Coronary artery bypass graft surgery? If **YES** please give date(s): DD MM YY	☐	☐
5	If **YES** to any of the above, are there any physical health problems (e.g. Mobility/arthritis. COPD) that would make the applicant unable to undertake 9 minutes of the standard Bruce Protocol ETT? If **YES,** please give dates and details in the **Additional Information** section.	☐	☐

4B CARDIAC ARRHYTHMIA

		Yes ☐	No ☐
	Is there a history of, or evidence of, cardiac arrhythmia? If **NO**, go to Section 4C. If **YES**, please answer all questions below and give details in the **Additional Information** section.		
1	Has there been a **significant** disturbance of cardiac rhythm causing/ likely to cause incapacity in the last 5 years?	☐	☐
2	Has the arrhythmia been controlled satisfactorily for at least 3 months?	☐	☐
3	Has an ICD (Implanted Cardiac Defibrillator) or biventricular pacemaker with defibrillator/ cardiac resynchronisation therapy defibrillator (CRST-D type) been implanted?	☐	☐
4	Has a pacemaker or a biventricular pacemaker/ cardiac resynchronisation therapy pacemaker (CRT-P type) been implanted? If **YES**:	☐	☐
	a Please give date of implantation:		
	b Is the applicant free of symptoms that caused the device to be fitted?	☐	☐
	c Does the applicant attend a pacemaker clinic regularly?	☐	☐

GP Signature _____ Date _____

4C	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? If **NO,** go to Section **4D.** If **YES,** please answer the questions below and give details in the **Additional Information** section					**Yes** ☐	**No** ☐
1	Peripheral Arterial Disease (excluding Buerger's Disease)				☐	☐
2	Does the applicant have claudication? If **YES,** would the applicant be able to undertake 9 minutes of the standard Bruce Protocol ETT?				☐ ☐	☐ ☐
3	Aortic Aneurysm? If **YES:**				☐	☐
	a	Site of Aneurysm (please tick):	Thoracic ☐	Abdominal ☐		
	b	Has it been repaired successfully?			☐	☐
	c	Please provide the latest transverse aortic diameter measurement and date obtained using measurement and date boxes.				
		Latest aortic diameter measurement:		Date obtained: DD MM YY		
4	a	Dissection of the Aorta? If **YES**, please provide copies of all reports including those dealing with any surgical treatment.			☐	☐
	b	If **YES**, has the dissection been successfully repaired?			☐	☐
5	Is there history of Marfan's disease?				☐	☐
	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.			☐	☐

4D	VALVULAR/CONGENITAL HEART DISEASE		
Is there a history of, or evidence of valvular or congenital heart disease?		**Yes** ☐	**No** ☐
If **NO,** go to Section 4E. If **YES,** please answer all questions below and give details in the **Additional Information** section.			
1	Is there a history of congenital heart disease?	☐	☐
2	Is there a history of heart valve disease?	☐	☐
	a If **YES**, are they symptomatic?	☐	☐
3	Is there a history of aortic stenosis? 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?	☐	☐

GP Signature _____ Date _____

4E	CARDIAC OTHER		
Is there a history or evidence of heart failure? If **NO,** go to Section 4F. If **YES,** please answer **ALL** questions below and give details in the **Additional Information** section.		**Yes** ☐	**No** ☐
a	Please provide the NYHA class, if known:		
b	Established cardiomyopathy?	☐	☐
c	Has a left ventricular assist device (LVAD) or other cardiac assist device been implanted?	☐	☐
d	A heart or heart/lung transplant?	☐	☐
e	Evidence or history of pulmonary arterial hypertension?	☐	☐

4F	CARDIAC CHANNELOPATHIES		
Is there a history or evidence of the following conditions? If **NO**, go to section 4G		☐	☐
1	Brugada syndrome?	☐	☐
2	Long QT syndrome?	☐	☐
If **YES** to either, please give details in the **Additional Information** section			

4G	BLOOD PRESSURE (This section must be filled in for all applicants)		
If resting blood pressure is 180mm/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:		
	1 B.P. reading:	Date: DD MM YY	
	2 B.P. reading:	Date: DD MM YY	
	3 B.P. reading:	Date: DD MM YY	

4H	CARDIAC INVESTIGATIONS (This section must be filled in for all applicants)		
Have any cardiac investigations been undertaken or planned? If **NO**, go to section 5. If **YES**, please answer questions 1 - 5		**Yes** ☐	**No** ☐
1	Is there a history of the following:		
	a Left bundle branch block (LBBB)?	☐	☐
	b Right bundle branch block (RBBB)?	☐	☐
	c Paced rhythm?	☐	☐
If **YES** to a, b or c above, please give details in the **Additional Information** section			

GP Signature _____ Date _____

2	Has an exercise ECG been undertaken (or planned)?		☐	☐
	a	If **YES,** please provide date and give details in the **Additional Information** section: DD MM YY		
3	Has an echocardiogram been undertaken (or planned)?		☐	☐
	a	If **YES,** please provide date and give details in the **Additional Information** section: DD MM YY		
	b	If undertaken, is or was the left ventricular ejection fraction greater than or equal to 40%?	☐	☐
4	Has a coronary angiogram been undertaken (or planned)?		☐	☐
	a	If **YES,** please provide date and give details in the **Additional Information** section**:** DD MM YY		
5	Has a myocardial perfusion scan, stress echo study or cardiac MRI been undertaken (or planned)?		☐	☐
	a	If **YES,** please provide date and give details in the **Additional Information** section: DD MM YY		

GP Signature _____ Date _____

Section 5

PSYCHIATRIC ILLNESS

			Yes ☐	No ☐
Is there any significant mental illness or cognitive impairment likely to affect safe driving? If **NO,** please go to Section 6.				
If **YES** please answer the following questions and give date(s), prognosis, period of stability and details of medication, dosage and any side effects in the **Additional Information** section. (Please enclose relevant notes). (If applicant remains under specialist clinic(s) please give details in the **Additional Information** section).				
1	Significant psychiatric disorder within the past 6 months?		☐	☐
2	Psychosis or hypomania/mania within the past 12 months?		☐	☐
3	Severe depression within the past 6 months?		☐	☐
4	a	Dementia or cognitive impairment?	☐	☐
	b	Are there any concerns which have resulted in ongoing investigations for such possible diagnoses?	☐	☐

SUBSTANCE MISUSE

			Yes ☐	No ☐
Is there a history of drug/ alcohol misuse or dependence?				
1	Is there a history of an alcohol use disorder (sufficient to cause significant physical, mental or social consequences) in the past 10 years?		☐	☐
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?		☐	☐
	a	Required medical assistance withdrawal? If **YES**, date treatment ended: DD MM YY	☐	☐
	b	Alcohol withdrawal seizure? If **YES**, date of last event: DD MM YY	☐	☐
3	Based on their clinical record and/ or account of drinking provided to you, is their alcohol consumption:			
	a	Abstinent? If **YES**, for how long:	☐	☐
	b	Controlled? If **YES**, for how long:	☐	☐
4	Use of illegal drugs or other substances, or misuse of prescription medication in the last 6 years?		☐	☐
	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: DD MM YY	☐	☐

GP Signature _____ Date _____

Section 6

SLEEP DISORDERS

Please answer all questions in this section. If your answer is **YES** to any question please give full details in the **Additional Information** section**.**

			Yes	No
1	Is there a history of, or evidence of, Obstructive Sleep Apnoea Syndrome or any other medical condition causing excessive sleepiness?		☐	☐
	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. Please give details in the **Additional Information** section.		
	b	Please answer questions (i) to (vi) for **all** sleep conditions		
	(i)	Date of diagnosis: DD MM YY		
	(ii)	Is it controlled successfully?	☐	☐
	(iii)	Is applicant compliant with treatment	☐	☐
	(iv)	Date of last review: DD MM YY		

OTHER MEDICAL CONDITIONS

1	Is there a history or evidence of narcolepsy?		☐	☐
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?		☐	☐
3	Is there any illness that may cause significant fatigue or cachexia that affects safe driving?		☐	☐
4	Does the applicant have a history of liver disease of any origin?		☐	☐
	a	If **YES** to Question 4, is this the result of alcohol misuse? If **YES** to Question 4A**,** please provide details in the **Additional Information** section.	☐	☐
6	Is there any history of renal failure? If **YES,** please provide details in the **Additional Information** section.		☐	☐
7	Does the applicant have severe symptomatic respiratory disease causing chronic hypoxia?		☐	☐
10	Does the applicant have any other medical condition that could affect safe driving? If **YES,** please provide details in the **Additional Information** section.		☐	☐

GP Signature _____ Date _____

Section 7

MEDICATION

			Yes ☐	No ☐
1	Is the applicant currently prescribed any of the following medication:			
	a	Anti-seizure?	☐	☐
	b	Clozapine?	☐	☐
	c	Sulphonylurea or a Glinide?	☐	☐
	d	Insulin?	☐	☐

GP Signature _____ Date _____