

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

Applicant's details: (please complete)

Full name: **Date of Birth:**.....

Current address:

Applicant's consent and declaration:

(Please read the following carefully before signing and dating the declaration).

I authorise my General Practitioner(s) and Specialist(s) to release medical information about my condition, together with any relevant information relevant to fitness to drive, to the Licensing Section, Newcastle City Council for the purpose of the Council (by its Officers and/or Members) of assessing my fitness to drive a hackney carriage private hire vehicle licensed by that Council.

I declare that to the best of my knowledge and belief all information given by me to my doctors in connection with the examination or the completion of the DVLA Group 2 medical examination report are true. In the event that the Council is not satisfied of my fitness to drive a hackney carriage or private hire vehicle, I confirm that I may, at my own cost, submit such further medical evidence to the Council as I consider appropriate.

Signed:..... **Date:**

TO THE G.P. This form must be completed in full by the applicant's own G.P. or a medical practitioner who has reviewed the applicant's medical records. Please answer all questions and once completed sign the declaration at the end.

The Councils' policy on medical fitness requires that taxi drivers meet Group 2 Entitlement, as set out in the DVLA publication 'A Guide to the current Medical Standards of Fitness to Drive'. This guide makes reference to current best practice guidance contained in the booklet 'Fitness to Drive' which recommends the medical standard applied by DVLA in relation to bus and lorry drivers should also be applied by local authorities to taxi drivers.

(a)	Is the applicant a registered patient of the surgery / medical centre at which you practice as a registered medical practitioner? If NO please provide details of patient's registered GP and surgery. Doctor's Name: Address:	YES	NO
(b)	Have you reviewed the above applicant's medical records?	YES	NO

1. VISION:

i	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)	Yes	No
---	--	-----	----

ii	Is there a history of blackout or impaired consciousness within the last 5 years? If YES please give dates and details at Section 8 :	Yes	No
iii	Is there a history of, or evidence of, any of the conditions listed at a – g below? If NO go to Section 3. If YES please answer the following questions, give dates and full details and supply any relevant reports. (a) Stroke / TIA (<i>please delete as appropriate</i>) If YES please give date: Has there been a full recovery? (b) Sudden and disabling dizziness/vertigo within the last one 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/abnormality (g) Chronic neurological disorders e.g. Parkinson's disease, Multiple Sclerosis	Yes	No

3. DIABETES MELLITUS

i	Does the patient have diabetes mellitus? If NO please go to Section 4 . If YES please answer the following questions.	YES	NO
ii	Is the diabetes managed by:- (a) Insulin? If YES please give date started on insulin: (b) Exenatide/Byetta? (c) Oral hypoglycaemic agents and diet? If YES please provide details of medication: (d) Diet only?	Yes	No
iii	Does the patient test blood glucose at least twice every day?	Yes	No
iv	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?	Yes	No
v	Has there been any laser treatment for retinopathy? If YES please give date(s) of treatment	Yes	No
vi	Is there a history of hypoglycaemia during waking hours in the last 12 months requiring assistance? If YES to any of 4 – 6 above please give details in Section 8 .	Yes	No

4 PSYCHIATRIC ILLNESS		
	<p>Is there a history of, or evidence of any of the conditions listed at 1 – 7 below? If NO please go to Section 5.</p> <p>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 Section 8. (Please enclose relevant notes). (If patient remains under specialist clinic(s) please give details in Section 8).</p>	YES NO
i	Significant psychiatric disorder within the past 6 months?	Yes No
ii	A psychotic illness within the past 3 years, including psychotic depression?	Yes No
iii	Dementia or cognitive impairment?	Yes No
iv	Persistent alcohol misuse in the past 12 months?	Yes No
v	Alcohol dependency in the past 3 years?	Yes No
vi	Persistent drug misuse in the past 12 months?	Yes No
vii	Drug dependency in the past 3 years?	Yes No
5 CARDIAC		
	<p>Is there a history of, or evidence of, Coronary Artery Disease? If NO please go to Section 5B If YES please answer all questions below and give details at Section 8 of the form and enclose relevant hospital notes.</p>	YES NO
5A CORONARY ARTERY DISEASE		
i	<p>Acute Coronary Syndromes including Myocardial Infarction? If YES please give date(s):</p> <p>.....</p>	Yes No
ii	<p>Coronary artery by-pass graft surgery? If YES please give date(s):</p> <p>.....</p>	Yes No
iii	<p>Coronary Angioplasty (P.C.I.)? If YES please give date of most recent intervention:</p> <p>.....</p>	Yes No
iv	<p>Has the patient suffered from Angina? If YES please give the date of the last attack:</p> <p>.....</p>	Yes No
Please go to next Section 5B		
5B CARDIA ARRHYTHMIA		
	Is there a history of, or evidence of, cardiac arrhythmia?	YES NO

i	Is there a history of congenital heart disorder?	Yes	No
ii	Is there a history of heart valve disease?	Yes	No
iii	Is there any history of embolism? (not pulmonary embolism)	Yes	No
iv	Does the patient currently have significant symptoms?	Yes	No
v	Has there been any progression since the last licence application? (if relevant)	Yes	No
5E	CARDIAC OTHER		
	Does the patient have a history of ANY of the following conditions: If NO go to Section 5F If YES please answer all questions below and give details in Section 7 of the form	YES	NO
	(a) A history of, or evidence of, heart failure?	Yes	No
	(b) Established cardiomyopathy?	Yes	No
	(c) A heart or heart/lung transplant?	Yes	No
5F	CARDIAC INVESTIGATIONS (This section must be filled in for all patients) (Please provide relevant reports)		
i	Has a resting ECG been undertaken? If YES does it show:	YES	NO
	(a) Pathological Q waves?	Yes	No
	(b) Left bundle branch block?	Yes	No
	(c) Right bundle branch block?	Yes	No
ii	Has the exercise ECG been undertaken (or planned)? If YES please provide date and give details in Section 8 :	Yes	No
iii	Has an echocardiogram been undertaken (or planned)? (a) If YES please give date and give details in Section 8 :	Yes	No
	(b) If undertaken is/was the left ventricular ejection fraction greater than or equal to 40%?	Yes	No
iv	Has a coronary angiogram been undertaken (or planned)? If YES please provide date and give details in Section 8 :	Yes	No
v	Has a 24 hour ECG tape been undertaken (or planned)? If YES please provide date and give details in Section 8 :	Yes	No
vi	Has a Myocardial Perfusion Scan or Stress Echo study been undertaken (or planned)? If YES please provide date and give details in Section 8 :	Yes	No

Please go to next Section 5G

5G BLOOD PRESSURE (This section must be filled in for all patients)

i Is today's best systolic pressure reading 180mm Hg or more?
(Please give reading) **Yes No**

(BP reading:)

ii Is today's best diastolic pressure reading 100mm Hg or more?
(Please give reading) **Yes No**

(BP reading:)

iii Is the patient on anti-hypertensive treatment? **Yes No**

If **YES** to any of the above please provide three previous readings with dates if available:

1. B.P reading: Date:

2. B.P reading: Date:

3. B.P reading: Date:

6. GENERAL

(Please answer all questions in this section.

If your answer is **YES** to any question please give full details in **Section 8.**

i Is there **currently** a disability of the spine or limbs likely to impair control of the vehicle? **Yes No**

ii 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?
.....
.....
.....

iii Is there any evidence the patient has a cancer that causes fatigue or cachexia that affects safe driving? **Yes No**

iv Is the patient profoundly deaf? **Yes No**

If **YES** is the patient able to communicate in the event of an emergency by speech or by using a device e.g. a textphone? **Yes No**

v Is there a history of either renal or hepatic failure? **Yes No**

vi Is there a history of, or evidence of sleep apnoea syndrome?
If **YES** please provide details:

(a) Date of diagnosis:
.....

	(b) Is it controlled successfully? (c) If YES please state treatment: (d) Please state period of control: (e) Please provide neck circumference (f) Please provide girth measurement in cm..... (g) Date last seen by consultant	Yes	No
vi	Does the patient suffer from narcolepsy/cataplexy?	Yes	No
vii	Is there any other Medical Condition causing daytime sleepiness? If YES please provide details: (a) Diagnosis: (b) Date of diagnosis: (c) Is it controlled successfully? (d) If YES please state treatment: (e) Please state period of control (f) Date last seen by consultant:	Yes	No
viii	Does the patient have severe symptomatic respiratory disease causing chronic hypoxia?	Yes	No
ix	Does any medication currently taken cause the patient side effects that could affect safe driving? If YES please provide details:	Yes	No
x	Does the patient have any other medical condition that could affect safe driving? If YES please provide details:	Yes	No

7. ALCOHOL AND/OR DRUG MIS-USE
(Please answer all questions in this section.
If your answer is **YES** to any question please give full details in **Section 8**.)

i	Does the patient show any evidence of being addicted to excessive use of alcohol?	Yes	No
ii	Does the patient show any evidence of being addicted to excessive use of drugs?	Yes	No

