Neath Port Talbot
Castell-nedd Port Talbot
County Borough Council Cyngor Bwrdeistref Sirol

# Medical Report (in confidence)

## on an application for Driver's Licence

The Neath Port Talbot Council has adopted the Group II medical standards as specified in the D.V.L.A. "At a Glance" booklet. These standards apply to drivers of passenger carrying vehicles and are higher than those required for private car drivers.

If this is your first application for a driver licence you **must** submit this Medical Report form, completed by your Doctor. You must also do this if you are applying to renew your licence on or after the age of 45 and on each renewal of the licence until the age of 65. From the age of 65 a Medical Report form is required annually.

WHAT YOU HAVE TO DO

1 Before consulting your Doctor please read the notes overleaf entitled ("Medical standards for drivers of passenger carrying vehicles"). If you have any of these conditions it is unlikely that you will be granted a licence.

2 If, after reading the notes, you have any doubts about your ability to meet the medical or eyesight standards, consult your Doctor/Optician before you arrange for this medical form to be completed. The Doctor will normally charge you for completing it. In the event of your application being refused, the fee you pay the Doctor is not refundable. The Local Authority has no responsibility for the fee payable to the Doctor.

3 Fill in Section 8 and Section 9 of this report in the presence of the Doctor carrying out the examination.

4 This report is valid for a period of four months subsequent to the Doctor signing the report.

5 This medical form must be submitted with your application form.

## WHAT THE DOCTOR HAS TO DO

1 Please arrange for the patient to be seen and examined. **You must have access to the applicant's medical records and you will be asked to sign a declaration confirming that these records have been considered when completing this medical assessment.**

2 Please complete sections 1-7 and 10 of this report. You may find it helpful to consult the DVLA's "At a Glance" booklet. We would need to know the applicant's full name, address and date of birth.

3 Please note that Group II standards are applicable as detailed in the D.V.L.A "At a Glance" booklet.

4 Applicants who may be asymptomatic at the time of the examination should be advised that, if in future they develop symptoms of a condition which could affect safe driving and they hold a Driver Licence they must inform the Licensing Section, Neath Port Talbot CBC, Civic Centre, Port Talbot, SA13 1PJ – **IMMEDIATELY**.

5 Please ensure that you have completed all the sections

## MEDICAL STANDARDS FOR DRIVERS OF PASSENGER CARRYING VEHICLES

Medical standards for drivers of Passenger Carrying Vehicles are higher than those required for car drivers. The following conditions are likely to be a bar to the holding of a driver licence.

### Epileptic Attack

Applicants must have been free of epileptic seizures for at least the last ten years and have not taken anti epileptic medication during this ten-year period. The Local Authority are likely to refuse or revoke the licence if these conditions cannot be met.

### Diabetes

Insulin treated diabetics licensed before the 1st April 1991 are dealt with individually and licensing is subject to satisfactory annual consultant medical certification, and to the proviso that they are not suffering from any other relevant disabilities. Since the 1st April 1991 diabetic patients on insulin are barred from first applying for a passenger carrying vehicle driving licence and from renewing thereafter.

### Eyesight

All applicants, for whatever category of vehicle, must be able to read in good daylight a number plate at 20.5 metres (67 feet), and, if glasses or corrective

lenses are required to do so, these must be worn while driving. In addition:

Applicants for passenger carrying vehicle entitlement must have:

- A visual acuity of at least 6/9 in the better eye; and
- A visual acuity of at least 6/12 in the worse eye; and
- If these are achieved by correction, the uncorrected visual acuity in each eye must be no less than 3/60

Applicant's are also barred from holding passenger carrying vehicle entitlement if they have:

- Uncontrolled Diplopia (double vision); or
- Do not have a normal binocular field of vision

Other medical conditions
In addition to those medical conditions covered above, applicants (or licence holders) are likely to be refused if they are unable to meet the national recommended guidelines in the following cases:-

- Within 3 months of myocardial infarction, any episode of unstable angina, CABG or coronary angioplasty
- A significant disturbance of cardiac rhythm occurring within the past 5 years unless special criteria are met
- Suffering from or receiving medication for angina or heart failure
- Hypertension where the BP is persistently 180 systolic or over or 100 diastolic or over
- A stroke, or TIA within the last 12 months
- Unexplained loss of consciousness within the past 5 years
- Meniere's and other conditions causing disabling vertigo, within the past 1 year, and with a liability to recurrence
- Recent severe head injury with serious continuing after effects, or major brain surgery
- Parkinson's disease, multiple sclerosis or other "chronic" neurological disorders likely to affect limb power and co-ordination
- Suffering from a psychotic illness in the past 3 years, or suffering from dementia
- Alcohol dependency or misuse, or persistent drug or substance issue or dependency in the past 3 years
- Insuperable difficulty in communicating by telephone in an emergency
- Any other serious medical condition which may cause problems for road safety when driving a Passenger Carrying Vehicle
- If major psychotropic or neuroleptic is being taken
- Any malignant condition within the last 2 years likely to metastasise to the brain e.g. Ca lung or malignant melanoma.

## MEDICAL EXAMINATION

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

**Section 1 – Applicant Details**

| Name |
|---|
| Address |
| |
| |

Date of Birth

Home Telephone No.

Work/Daytime No.

**Applicant's GP/Group Practice**

| GP/Group Name |
|---|
| Address |
| |
| |
| |
| Telephone No. |

**Applicant's Consultant/Specialist**
(If Applicable)

| Consultants Name |
|---|
| Address |
| |
| |
| |
| Telephone No. |

Date last seen

Applicant's weight

Applicant's height

Please give details of smoking habits, if any

Please give number of alcohol units taken each week

Date when first licensed to drive a motor vehicle

Applicant Name ………………………… D.O.B ………………..

**Section 2 – Vision**

(Please see eyesight notes on page 2 & 3)

| | YES | NO |
|---|---|---|
| **1.** Is the visual acuity as measured by the Snellen chart at least 6/9 in the better eye. | | |
| **2.** Is the visual acuity as measures by the Snellen chart at least 6/12 in the other? (corrective lenses may be worn) | | |
| **3.** Do corrective lenses have to be worn to achieve this standard | | |
| **a.** If yes, is the uncorrected acuity at least 3/60 in the right eye | | |
| **b.** Is the uncorrected acuity by the Snellen chart AT least 3/60 in the left eye? (3/60 being the ability to read the 60 line of the Snellen yes chart at 3 metres) | | |
| **c.** Is the correction well tolerated<br>Please state all the visual acuities for all applicants<br>UNCORRECTED **Right** ☐ **Left** ☐ CORRECTED (if applicable) **Right** ☐ **Left** ☐ | | |
| **4.** Is there a full binocular field of vision? (central and peripheral)<br>(If no, and there is a visual field defect please give details in Section 7 and enclose a copy of recent field charts, if possible) | | |
| **5.** Is there uncontrolled diplopia<br>(If yes, please give details in Section 7) | | |
| **6.** Does the applicant have any other ophthalmic condition<br>(If yes, please give details in Section 7) | | |
| Please state if you are using a half size Snellen chart at 3m | | |

Applicant Name ………………………… D.O.B ………………..

**Section 3 – Nervous System**

| | | YES | NO |
|---|---|---|---|
| **1.** | Has the applicant had any form of epileptic attack | | |
| **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 (If yes, please give date(s) and details in Section 7) | | |
| **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) | | |
| **4.** | Is there a history of sudden disabling dizziness/vertigo within the last 1 year with a liability to recur (If yes, please give date(s) and details in Section 7) | | |
| **5.** | Does the patient have a pathological sleep disorder (If yes, has it been controlled successfully please give details in Section 7) | | |
| **6.** | Is there a history of chronic and/or progressive neurological disorder (If yes, please give date(s) and details in Section 7) | | |
| **7.** | Is there a history of brain surgery (If yes, please give date(s) and details in Section 7) | | |
| **8.** | Is there a history of serious head injury (If yes, please give date(s) and details in Section 7) | | |
| **9.** | Is there a history of brain tumor, either benign or malignant, primary or secondary (If yes, please give date(s) and details in Section 7) | | |

**Section 4 - Diabetes Mellitus**

| | | YES | NO |
|---|---|---|---|
| **1.** | Does the applicant have diabetes mellitus (If yes, please answer the following questions. If no, proceed to Section 5) | | |
| **2.** | Is the diabetes managed by insulin | | |
| **b** | If yes, date started on insulin | | |
| **c** | Is the diabetes managed by oral hypoglycemic agents and diet | | |
| **d.** | Is the diabetes managed by diet only | | |
| **3.** | Is the diabetic control generally satisfactory | | |
| **4.** | Is there evidence of loss of visual field | | |
| **b.** | Has there been bilateral laser treatment. (If yes, please give date) | | |
| **c.** | Is there evidence of severe peripheral neuropathy | | |
| **d.** | Is there evidence of significant impairment of limb function or joint position sense | | |
| **e.** | Is there evidence of significant episodes of hypoglycemia | | |
| **f.** | Is there evidence of complete loss of warning systems of hypoglycemia | | |

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

Applicant Name .............................                    D.O.B …………………………….

**Section 5 - Psychiatric Illness**

| | | YES | NO |
|---|---|---|---|
| **1.** | Has the applicant suffered from or required treatment for a psychotic illness in the past 3 years<br>**(**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<br>(If yes, please give date(s), details of medication and period of stability in Section 7) | | |
| **3.** | Is there any evidence of dementia or cognitive impairment<br>(If yes, please give details in Section 7) | | |
| **4.** | Is there a history or evidence of alcohol misuse or dependency in the past 3 years | | |
| **5.** | Is there a history or evidence of persistent drug or substance misuse or dependency in the past 3 years<br>(If yes, to question 4 or 5, please give details in Section 7) | | |

**Section 6 - General**

| | | YES | NO |
|---|---|---|---|
| **1.** | Does the applicant currently have**,** a significant disability of the spine or limbs which is likely to impair control of the vehicle<br>(If yes, please give details in Section 7) | | |
| **2.** | Is there a history of bronchogenic carcinoma or other malignant tumor, for example Malignant melanoma with a significant liability to metastasise cerebrally | | |
| **a.** | If yes**,** please give dates and diagnosis and state whether there is current evidence of dissemination.)<br>……………………………………………………………………………………..<br>…………………………………………………………………………………….. | | |
| **3.** | Is the applicant profoundly deaf | | |
| **a.** | If yes**,** could this be overcome by any means to allow a telephone to be used in an emergency. | | |

Applicant Name .............................. D.O.B …………………………….

## Section 7 - Cardiac

### A Coronary Artery Disease

| Is there a history of: | | YES | NO |
|---|---|---|---|
| **1.** | Myocardial Infarction | | |
| **a.** | If yes, please give date(s) | | |
| **2.** | Coronary artery by-pass graft | | |
| **a.** | If yes, please give date(s) | | |
| **3.** | Coronary Angioplasty | | |
| **a.** | If yes, please give date(s) | | |
| **4.** | Any other Coronary artery procedure<br>(If yes please give details in Section 7) | | |
| **5.** | Has the applicant suffered from Angina | | |
| **a.** | If yes, please give the date of the last attack | | |
| **6.** | Has the applicant suffered from Heart Failure | | |
| **a.** | If yes, is the applicant still suffering from Heart Failure or only remains controlled by use of medication | | |
| **7.** | Has a resting ECG been undertaken. (If no, proceed to question 8) | | |
| **a.** | If yes, please give date | | |
| **b.** | Does it show pathological Q waves | | |
| **c.** | Does it show Left Bundle branch block | | |
| **8.** | Has an exercise ECG been undertaken (or planned)<br>(If yes, please give date and give details in Section 7) | | |
| Sight/copy of the exercise test result/report (if done in the last 3 years) would be useful | | | |
| **9.** | Has an angiogram been undertaken (or planned)<br>(If yes, please give date and give details in Section 7) | | |

### B Cardiac Arrhythmia

| | | YES | NO |
|---|---|---|---|
| **1.** | Has the applicant had a significant documented disturbance of cardiac rhythm within the Past 5 years<br>(If yes, please give details in Section 7). (If No, proceed to Section C overleaf) | | |
| **2.** | Has the arrhythmia (or its medication) caused symptoms of sudden dizziness or impairment of consciousness or any symptom likely to distract attention during driving within the past 2 years | | |
| **3.** | Has Echocardiography been undertaken<br>(If Yes, please give details in Section 7) | | |
| **4.** | Has an exercise test been undertaken<br>(If yes, please give details in Section 7) | | |
| **5.** | Has a cardiac defibrillator or antiventricular tachycardia device been implanted | | |
| **6.** | Has a pacemaker been implanted<br>(If no, proceed to Section C overleaf) | | |
| **a.** | If yes, was it implanted to prevent bradycardia | | |
| **b.** | Is the applicant continuing to suffer from sudden and/or disabling symptoms | | |
| **c.** | Does the applicant attend a pacemaker clinic regularly | | |

Applicant Name ............................. D.O.B …………………………….

## C Other Vascular Disorders

| | | YES | NO |
|---|---|---|---|
| **1.** | Is there a history of Aortic aneurysm (thoracic or abdominal) with a transverse diameter of 5cms or more? (If no, proceed to Section D) | | |
| **a.** | If yes, has the aneurysm been successfully repaired | | |
| **2.** | Has there been dissection of the Aorta | | |
| **3.** | Is there a history or evidence of peripheral vascular disease (If yes, please give details in Section 7) | | |

## D Blood Pressure

| | | YES | NO |
|---|---|---|---|
| **1.** | Does the patient suffer hypertension requiring treatment | | |
| **a.** | If yes, is the systolic pressure consistently greater than 180 | | |
| **b.** | Is the diastolic pressure consistently greater than 100 | | |
| **c.** | Does the hypertensive treatment cause side effects likely to affect driving ability | | |
| **2** | Is it possible that the patient suffers from hypertension but as yet the diagnosis is not definitely established | | |
| **a.** | If yes, please supply last 3 readings and dates obtained | | |

## E Valvular Heart Disease

| | | YES | NO |
|---|---|---|---|
| **1.** | Is there a history of acquired valvular heart disease (with or without surgery) (If no, proceed to Section F) | | |
| **2.** | Is there a history of embolism (not pulmonary embolism) (If yes, please give details in Section 7) | | |
| **3.** | Is there a persistent dilation of hypertrophy of either ventricle (If yes, please give details in Section 7) | | |

## F Cardiomyopathy

| | | YES | NO |
|---|---|---|---|
| **1.** | Is there established cardiomyopathy | | |
| **2.** | Has there been a heart or heart/lung transplant? (If yes, please give details in Section 7) | | |

## G Congenital Heart Disorders

| | | YES | NO |
|---|---|---|---|
| **1.** | Is there a congenital heart disorder (If yes, please give details in Section 7) | | |
| **a.** | If yes, is it currently regarded as minor | | |
| **2.** | Is the patient in the care of a Specialist Cardiac clinic (If yes, please give details in Section 7) | | |

Please remember to complete Section 7 if you have answered yes to any of the questions

Applicant Name .............................. D.O.B …………………………..

## Section 8 – Other Information

Please forward copies of all hospital notes if available

Applicant Name ............................... D.O.B …………………………..

## Section 9 – Applicant's Consent and Declaration

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

**Please sign statement below.**
I authorise my Doctor(s) and Specialist(s) to release reports to the Neath Port Talbot CBC Licensing Section about my medical condition.

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** the Neath Port Talbot CBC Licensing Section to release medical information to my Doctor(s) and/or Specialist(s) 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, for the release of medical reports from your Doctor(s), because we might wish you to be examined, and the Neath Port Talbot CBC need to know the medical details, or because we need further information.
This will enable the medical adviser to understand about a patient's medical condition in order to produce a helpful report if required. 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 Doctor(s).

We hope you will find this helpful and reassuring and will return the signed consent so that we might proceed with our investigations.

Applicant Name ............................... D.O.B …………………………..

**Section 10 – Doctor's Declaration**

| When making the declaration below, I confirm that I have had full access to and given due regard to the applicant's medical records.<br><br>Signature of Doctor ________________________________ |
|---|

Sign either declaration 1 or declaration 2 below

| Declaration 1 | Declaration 2 |
|---|---|
| I certify that I have examined the above named person and that he/she **Meets** the group 2 standards to drive a hackney carriage or private hire vehicle<br><br>Signature of Doctor<br><br>_____________________________ | I certify that I have examined the above named person and that he/she does **Not Meet** the group 2 standards to drive a hackney carriage or private hire vehicle<br><br>Signature of Doctor<br><br>__________________________ |

## Doctor's Details

| Name |
|---|
| Address |
| |
| |

| Surgery Stamp |
|---|
| |

| Signature of Doctor | | Date | |
|---|---|---|---|

Applicant Name ..............................          D.O.B …………………………..