4 PSYCHIATRIC ILLNESS

	Is there a history of, or evidence of any of the conditions listed at $1 - 7$ below? If NO please go to Section 5 .	YES	NO
	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).		
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
111	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 C.			
	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.	YES	NO
5A	CORONARY ARTERY DISEASE		
i	Acute Coronary Syndromes including Myocardial Infarction? If YES please give date(s):	Yes	No
ii	Coronary artery by-pass graft surgery? If YES please give date(s):	Yes	No
111	Coronary Angioplasty (P.C.I.)? If YES please give date of most recent intervention:	Yes	No
iv	Has the patient suffered from Angina? If YES please give the date of the last attack:	Yes	No
	Please go to next Section 5B		
5B	CARDIA ARRHYTHMIA		
	Is there a history of, or evidence of, cardiac arrhythmia? If NO , go to Section 5C If YES please answer all questions below and give details in Section 8 of the form	YES	NO
i	Has there been a significant disturbance of cardiac rhythm? i.e. Sinoatrial disease, significant atrio-ventricular conduction defect, atrial flutter/fibrillation, narrow or broad complex tachycardia in last 5 years?	Yes	No
ii	Has the arrhythmia been controlled satisfactorily for at least 3 months?	Yes	No
iii	Has an ICD or biventricular pacemaker (CRST-D type) been implanted?	Yes	No
iv	Has a pacemaker been implanted? If YES:	Yes	No
	(a) Please supply date:		
	(b) Is the patient free of symptoms that caused the device to be fitted?	Yes	No
	(c) Does the patient attend a pacemaker clinic regularly?	Yes	No
	Please go to next Section 5C		
5C	PERIPHERAL ARTERIAL DISEASE (EXCLUDING BUERGER'S DISEASE) AORTIC ANEURYSM/DISSE	CTION	
	Is there a history or evidence of ANY of the following: If NO go to Section 5D .	YES	NO
	If YES please answer the questions below and give details in Section 8 of the form.		
i	Peripheral Arterial Disease (excluding Buerger's Disease)	Yes	No
ii	Does the patient have claudication? If YES please give details as to how long in minutes the patient can walk at a brisk pace before being symptom limited	Yes	No

iii	Aortic Aneurysm If YES:
	(a) Site of Aneurysm (please tick): Thoraci
	(b) Has it been repaired successfully?
	(c) Is the transverse diameter currently >5.5 cms?
	If NO please provide latest measurement:
iv	Dissection of the Aorta repaired successfully If YES please provide copies of all reports to include those dealing v
	Please go to next Section 5D
5D	VALVULAR/CONGENITAL HEART DISEASE
	Is there a history of, or evidence of, valvular/congenital heart disease
	If NO go to Section 5E If YES please answer all questions below and give details in Section
i	Is there a history of congenital heart disorder?
ii	Is there a history of heart valve disease?
iii	Is there any history of embolism? (not pulmonary embolism)
iv	Does the patient currently have significant symptoms?
v	Has there been any progression since the last licence application? (i
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
i	A history of, or evidence of, heart failure?
ii	Established cardiomyopathy?
iii	A heart or heart/lung transplant?
5F	CARDIAC INVESTIGATIONS (Please answer ALL questions) (P
i	Has a resting ECG been undertaken? If YES does it show:
	(a) Pathological Q waves?
	(b) Left bundle branch block?
	(c) Right bundle branch block?
ii	Has the exercise ECG been undertaken (or planned)?
	If YES please provide date and give details in Section 8:
111	Has an echocardiogram been undertaken (or planned)?
	(a) If YES please give date and give details in Section 8 :
	(b) If undertaken is/was the left ventricular ejection fraction great
iv	Has a coronary angiogram been undertaken (or planned)?
	If YES please provide date and give details in Section 8:
v	Has a 24 hour ECG tape been undertaken (or planned)?
	If YES please provide date and give details in Section 8:
vi	Has a Myocardial Perfusion Scan or Stress Echo study been undertal
	If YES please provide date and give details in Section 8:

5

oracic	Abdominal		
		Yes	No
		Yes	No
	Date obtained:		
ling with any surgical	treatment	Yes	No
sease?		YES	NO
ction 8 of the form			
		Yes	No
n? (if relevant)		Yes	No
ns:		YES	NO
ction 8 of the form			
		Yes	No
		Yes	No
		Yes	No
s) (Please provide re	levant reports)		
		YES	NO
		Vaa	Na
		Yes	No
		Yes	No
reater than or equal	to 40%?	Yes	No
		Yes	No
		Yes	No
lertaken (or planned)	?	Yes	No

i	Is today's best systolic pressure reading 180mm Hg or more?	Yes	No		
	(Please give reading) (BP reading:)				
li	Is today's best diastolic pressure reading 100mm Hg or more? (Please give reading) (BP reading:)	Yes	No		
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?	Yes	No		
	If YES please give dates and diagnosis and state whether there is current evidence of dissemination?				
	(a) Is there any evidence the patient has a cancer that causes fatigue or cachexia that affects safe driving?	Yes	No		
iii	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		
v	Is there a history of, or evidence of sleep apnoea syndrome?	Yes	No		
	If YES please provide details:				
	(a) Date of diagnosis:				
	(b) Is it controlled successfully?	Yes	No		
-	(c) If YES please state treatment: (d) Please state period of control:				
	(e) Please provide neck circumference:				
	(f) Please provide girth measurement in cms:				
	(g) Date last seen by consultant:				
/i	Does the patient suffer from narcolepsy/cataplexy?	Yes	No		
'ii	Is there any other Medical Condition causing daytime sleepiness?	Yes	No		
	If YES please provide details:				
	(a) Diagnosis:				
	(b) Date of diagnosis:				
	(c) Is it controlled successfully?	Yes	No		
	(d) If YES please state treatment:				
	(f) Date last seen by consultant:				
iii	Does the patient have severe symptomatic respiratory disease causing chronic hypoxia?	Yes	No		
x	Does any medication currently taken cause the patient side effects that could affect safe driving? If YES please provide details:	Yes	No		
‹	Does the patient have any other medical condition that could affect safe driving?	Yes	No		

2. NERVOUS SYSTEM

	As I		eee ererem
	i		he patient had any form of epileptic attack? S please answer questions a – f below.
		(a)	Has the patient had more than one attack?
		(b)	Please give date of first and last attack: 1 st attack
		(c)	Is the patient currently on anti-epilepsy medication? If YES please give details of current medication:
		(d)	If treated, please give date when treatment ended:
٤		(e)	Has the patient had a brain scan? If YES please state dates
			MRI
		(f)	Has the patient had an EEG? If YES please provide date and supply reports if available:
	ii		re a history of blackout or impaired consciousness within the la S please give dates and details at Section 8:
	iii		re a history of, or evidence of, any of the conditions listed at a go to Section 3 .
			S please answer the following questions, give dates and full de
		(a)	Stroke / TIA (please delete as appropriate) If YES please give date:
			Has there been a full recovery?
		(b)	Sudden and disabling dizziness/vertigo within the last one ye
		(c)	Subarachnoid haemorrhage
		(d)	Serious head injury within the last 10 years
		(e)	Brain tumour, either benign or malignant, primary or seconda
		(f)	Other brain surgery/abnormality
		(g)	Chronic neurological disorders e.g. Parkinson's disease, Mul
	3. D	IABE	TES MELLITUS
	i	If NO	the patient have diabetes mellitus? please go to Section 4 . S please answer the following questions.
	ii		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
		(d)	Diet only?
	iii	Does	the patient test blood glucose at least twice every day?
	iv	Is ther	e evidence of:-
		(a)	Loss of visual field?
		(b)	Severe peripheral neuropathy, sufficient to impair limb function
		(c)	Diminished / Absent awareness of hypoglycaemia?
	v	Has th	ere been any laser treatment for retinopathy? If YES please g
	vi		e a history of hypoglycaemia during waking hours in the last 1
		II TES	to any of $4 - 6$ above please give details in Section 8.

	YES	NO
	Yes	No
Last attack		
	Yes	No
es and supply reports if available.	Yes	No
СТ		
	Yes	No
last 5 years?	Yes	No
a – g below?	Yes	No
letails and supply any relevant reports.		
	Yes	No
	Yes	No
year with a liability to recur	Yes	No
	Yes	No
	Yes	No
dary	Yes	No
	Yes	No
lultiple Sclerosis	Yes	No
	n na di Na hadiya	
	YES	NO
	Yes	No
	Yes	No
le details of medication:	Yes	No
	Yes	No
	Yes	No
tion for cofo driving?	Yes	No
tion for safe driving?	Yes	No No
give date(s) of treatment	Yes	NO
12 months requiring assistance?	Yes	No
	1	

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, South Tyneside Council for the purpose of the Council (by its Officers) of assessing my fitness to drive a hackney carriage or 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.

0	÷			
2	10	ne	α:	

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?	YES	NO
(b)	Have you reviewed the above applicant's medical records?	YES	NO
1. V	ISION:		
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	Do corrective lenses have to be worn to achieve this standard? If yes , is the:	Yes	No
	(a) Uncorrected acuity at least 3/60 in the right eye?	Yes	No
	 (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 6 metre Snellen chart at 3 metres) 	Yes	No
	(c) Correction well tolerated?	Yes	No
111	Please state the visual acuities of each eye in terms of the 6 metre Snellen chart. (Please convert any 3 metre readings to the 6 metre equivalent)		
	Uncorrected Corrected (if applicable)		
	Right Left Right Left		
iv	Is there a defect in the patient's binocular field of vision (central and/or peripheral)?	Yes	No
v	Is there diplopia (controlled or uncontrolled)?	Yes	No
vi	Does the patient have any other ophthalmic condition? If YES to questions 4, 5 or 6 please give details in Section 8 and enclose any relevant visual field charts or hospital letters.	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 Se
i	Does the patient show any evidence of being addicted to the exces
II	Does the patient show any evidence of being addicted to the exces
3.	Please forward copies of relevant hospita PLEASE DO NOT send any notes not rela

If the applicant/patient is not a registered patient with your practice or you have not reviewed his/her medical records then do not complete the declaration.

I certify that I am familiar with the current requirements of Group 2 medical standards applied by the DVLA in the current version

of "Medical Standards of Fitness to Drive".

I certify that I have reviewed the applicant's medical records and that in my opinion nothing therein contradicts or tends to contradict the information given to me by the applicant.

I certify that I have today undertaken a medical examination of the applicant for the purpose of assessing their fitness to act as a driver of a Hackney Carriage or Private Hire driver under the DVLA Group 2 medical standards

I certify that having regard to the foregoing, the applicant * MEETS / DOES NOT MEET (*delete as appropriate) the minimum standards required for the DVLA Group 2 medical standards.

Doctor's name:	Surgery Stamp:
Surgery name:	
Surgery address:	
Signed:	Date:

Section 8.		
cessive use of alcohol?	Yes	No
ccessive use of drugs?	Yes	No

ital notes only. lated to fitness to drive.

GP'S DECLARATION: Please read the following carefully before completing, signing and dating the declaration.

Medical Certificate Associated with an Application for a Licence to Drive a Hackney Carriage or Private Hire Vehicle

South Tyneside Council Regulatory Services Licensing Section, Town Hall & Civic Offices, Westoe Road, South Shields, NE33 2RL. Tel: (0191) 424 7695 Fax: (0191) 427 2666 Email: licensing@southtyneside.gov.uk





South Tyneside Council



