

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
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

	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
iii	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/DISSECTION			
	Is there a history or evidence of ANY of the following: If NO go to Section 5D . If YES please answer the questions below and give details in Section 8 of the form.	YES	NO
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): Thoracic Abdominal		
	(b) Has it been repaired successfully?	Yes	No
	(c) Is the transverse diameter currently >5.5 cms? If NO please provide latest measurement: Date obtained:	Yes	No
iv	Dissection of the Aorta repaired successfully If YES please provide copies of all reports to include those dealing with any surgical treatment.	Yes	No
	Please go to next Section 5D		
5D VALVULAR/CONGENITAL HEART DISEASE			
	Is there a history of, or evidence of, valvular/congenital heart disease?	YES	NO
	If NO go to Section 5E If YES please answer all questions below and give details in Section 8 of the form		
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 8 of the form	YES	NO
i	A history of, or evidence of, heart failure?	Yes	No
ii	Established cardiomyopathy?	Yes	No
iii	A heart or heart/lung transplant?	Yes	No
5F CARDIAC INVESTIGATIONS (Please answer ALL questions) (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)?	Yes	No
	(a) If YES please give date and give details in Section 8 :		
	(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

5G	BLOOD PRESSURE (Please answer ALL questions)		
i	Is today's best systolic pressure reading 180mm Hg or more? (Please give reading) (BP reading:)	Yes	No
ii	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? 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:	Yes	No
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? (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? 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
iv	Is there a history of either renal or hepatic failure?	Yes	No
v	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 cms: (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

2. NERVOUS SYSTEM

i	Has the patient had any form of epileptic attack? If YES please answer questions a – f below.	YES	NO
(a)	Has the patient had more than one attack?	Yes	No
(b)	Please give date of first and last attack: 1 st attack Last attack		
(c)	Is the patient currently on anti-epilepsy medication? If YES please give details of current medication:	Yes	No
(d)	If treated, please give date when treatment ended:		
(e)	Has the patient had a brain scan? If YES please state dates and supply reports if available. MRI CT	Yes	No
(f)	Has the patient had an EEG? If YES please provide date and supply reports if available:	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.	Yes	No
(a)	Stroke / TIA (<i>please delete as appropriate</i>) If YES please give date: Has there been a full recovery?	Yes	No
(b)	Sudden and disabling dizziness/vertigo within the last one year with a liability to recur	Yes	No
(c)	Subarachnoid haemorrhage	Yes	No
(d)	Serious head injury within the last 10 years	Yes	No
(e)	Brain tumour, either benign or malignant, primary or secondary	Yes	No
(f)	Other brain surgery/abnormality	Yes	No
(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:	Yes	No
(b)	Exenatide/Byetta?	Yes	No
(c)	Oral hypoglycaemic agents and diet? If YES please provide details of medication:	Yes	No
(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?	Yes	No
(b)	Severe peripheral neuropathy, sufficient to impair limb function for safe driving?	Yes	No
(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

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

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