



Culture And Environmental Protection,
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GROUP II MEDICAL EXAMINATION REPORT FORM

INFORMATION NOTES

It is a requirement under Section 57 of the Local Government (Miscellaneous Provisions) Act, 1976, to provide a Medical Examination Report to the effect that you are physically fit to drive a Hackney Carriage and / or Private Hire.

This form is to be completed by the applicant's own General Practitioner (GP) or another GP within the same practice and is for the confidential use of the Licensing Authority.

A Group II Medical Report Form is required on first licensing and thereafter from age 45, every five years until the age of 65. From the age of 65 a Group II Medical Report Form will be required annually.

Any fee charged is payable by the applicant directly to the Doctor or Occupational Health Service.

PLEASE COMPLETE IN BLOCK CAPITAL LETTERS IN BLACK INK

Licensing Officers **are not** permitted to complete or amend forms on behalf of applicants for legal reasons.

Patient's name		Date of Birth	
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Medical Examination Report To be filled in by the Doctor

The Patient must fill in sections 9 and 10 in the Doctor's presence (please use black ink)

- Please answer **all** questions.

Patient's weight (kg)	Height (cms)
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Details of smoking habits, if any
Number of alcohol units taken each week

Is the urine analysis positive for Glucose? (please tick ✓ appropriate box)	YES	NO
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Details of type of specialist(s)/ consultants, including address

1.	2.	3.	4.

Date of last Appointment

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Date when first licensed to drive a motor vehicle

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1. Vision

Please tick ✓ the appropriate

1. Is the visual acuity at least 6/9 in the better eye and at least 6/ 12 in the other? (corrective lenses may be worn) as measured with the full size 6m snellen chart	YES	NO
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2. 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 6m Snellen chart at 3 metres)	YES	NO
(c) correction well tolerated?	YES	NO

Patient's name		Date of Birth	
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3. Please state the visual acuities of each eye in terms of the 6m Snellen chart. Please convert any 3 metre readings to the 6 metre equivalent.			
Uncorrected		Corrected (if applicable)	
Right	Left	Right	Left
4. Is there a defect in the patient's binocular field of vision (central and/or peripheral)?			YES NO
5. Is there diplopia? (controlled or uncontrolled)?			YES NO
6. Does the patient have any other ophthalmic condition? If YES to 4, 5 or 6 please give details in Section 7 and enclose any relevant visual field charts or hospital letters.			YES NO

2. Nervous System

1. Has the patient had any form of epileptic attack? If YES , please answer questions a–f	YES	NO
(a) Has the patient had more than one attack?	YES	NO
(b) Please give date of first and last attack First attack _____ Last attack _____		
(c) Is the patient currently on anti-epilepsy medication? If Yes , please fill in current medication on the appropriate section on the front of this form	YES	NO
(d) If treated, please give date when treatment ended		
(e) Has the patient had a brain scan? If Yes , please state: MRI Date _____ CT Date _____ Please supply reports if available	YES	NO
(f) Has the patient had an EEG? If Yes , please provide dates _____ Please supply reports if available	YES	NO
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	YES	NO
3. 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 tick the relevant box(es) and give dates and full details at Section 7 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 1 year with a liability to recur	YES	NO
Patient's name		Date of Birth

(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

1. Does the patient have diabetes mellitus? If NO , please go to Section 4 . If YES , please answer the following questions.	YES	NO
2. 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 fill in current medication on the appropriate section on the front of this form. (d) Diet only?	YES YES YES YES	NO NO NO NO
3. Does the patient test blood glucose at least twice every day?	YES	NO
4. 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 YES YES	NO NO NO
5. Has there been laser treatment for retinopathy? If YES , please give date(s) of treatment	YES	NO
6. Is there a history of hypoglycaemia during waking hours in the last 12 months requiring assistance from a third party? If YES to any of 4–6 above, please give details in Section 7	YES	NO

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 . If YES please tick the relevant box(es) below and give date(s), prognosis, period of stability and details of medication, dosage and any side effects in Section 7 . NB. Please enclose relevant hospital notes. NB. If patient remains under specialist clinic(s) ensure details are filled in at the top of page 2	YES	NO
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Patient's name		Date of Birth	
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1. Significant psychiatric disorder within the past 6 months	YES	NO
2. A psychotic illness within the past 3 years, including psychotic depression	YES	NO
3. Dementia or cognitive impairment	YES	NO
4. Persistent alcohol misuse in the past 12 months	YES	NO
5. Alcohol dependency in the past 3 years	YES	NO
6. Persistent drug misuse in the past 12 months	YES	NO
7. Drug dependency in the past 3 years	YES	NO

5. Cardiac

Is there a history of, or evidence of, Coronary Artery Disease? If NO , go to Section 5B . If YES please answer all questions below and give details at Section 7 of the form and enclose relevant hospital notes.	YES	NO
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5a Coronary Artery Disease

1. Acute Coronary Syndromes including Myocardial Infarction? If Yes , please give date(s)	YES	NO
2. Coronary artery by-pass graft surgery? If Yes , please give date(s)	YES	NO
3. Coronary Angioplasty (P.C.I.) If Yes , please give date of most recent intervention	YES	NO
4. Has the patient suffered from Angina? If Yes , please give the date of the last known attack	YES	NO

Please go to next Section 5b

5b Cardiac 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 7 of the form.	YES	NO
1. 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
2. Has the arrhythmia been controlled satisfactorily for at least 3 months?	YES	NO
3. Has an ICD or biventricular pacemaker (CRST-D type) been implanted?	YES	NO
4. Has a pacemaker been implanted? If YES :- (a) Please supply date (b) Is the patient free of symptoms that caused the device to be fitted? (c) Does the patient attend a pacemaker clinic regularly?	YES YES YES	NO NO NO

Please go to Section 5c

Patient's name		Date of Birth	
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5c Peripheral Arterial Disease (excluding Buerger's Disease) Aortic Aneurysm/Dissection

Is there a history or evidence of ANY of the following: If YES please tick ✓ ALL relevant boxes below, and give details in Section 7 of the form. If NO go to Section 5D .	YES	NO
1. PERIPHERAL ARTERIAL DISEASE (excluding Buerger's Disease)	YES	NO
2. Does the patient have claudication? If YES for how long in minutes can the patient walk at a brisk pace before being symptom limited? Please give details	YES	NO
3. AORTIC ANEURYSM IF YES: (a) Site of Aneurysm: Thoracic / Abdominal (b) Has it been repaired successfully? (c) Is the transverse diameter currently > 5.5cms? If NO , please provide latest measurement and date obtained	YES YES YES	NO NO NO
4. 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 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 7 of the form.	YES	NO
1. Is there a history of congenital heart disorder?	YES	NO
2. Is there a history of heart valve disease?	YES	NO
3. Is there any history of embolism? (not pulmonary embolism)	YES	NO
4. Does the patient currently have significant symptoms?	YES	NO
5. Has there been any progression since the last licence application? (if relevant)	YES	NO

Please go to section 5E

5e Cardiac Other

Does the patient have a history of ANY of the following conditions: (a) a history of, or evidence of heart failure? (b) established cardiomyopathy? (c) a heart or heart/ lung transplant? If YES please give full details in Section 7 of the form. If NO, go to section 5f	YES YES YES YES	NO NO NO NO
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Patient's name		Date of Birth	
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5f Cardiac Investigations

This section must be filled in for all patients

<p>1. Has a resting ECG been undertaken?</p> <p>If YES, does it show:-</p> <p>(a) pathological Q waves?</p> <p>(b) left bundle branch block?</p> <p>(c) right bundle branch block?</p>	<p>YES</p> <p>YES</p> <p>YES</p> <p>YES</p>	<p>NO</p> <p>NO</p> <p>NO</p> <p>NO</p>
<p>2. Has an exercise ECG been undertaken (or planned)?</p> <p>If YES, please give date _____ and give details in Section 7</p> <p><i>Please provide relevant reports if available</i></p>	<p>YES</p>	<p>NO</p>
<p>3. Has an echocardiogram been undertaken (or planned)?</p> <p>(a) If YES, please give date _____ and give details in Section 7</p> <p>(b) If undertaken, is/was the left ventricular ejection fraction greater than or equal to 40%?</p> <p><i>Please provide relevant reports if available</i></p>	<p>YES</p>	<p>NO</p>
<p>4. Has a coronary angiogram been undertaken (or planned)?</p> <p>If YES, please give date _____ and give details in Section 7</p> <p><i>Please provide relevant reports if available</i></p>	<p>YES</p>	<p>NO</p>
<p>5. Has a 24 hour ECG tape been undertaken (or planned)?</p> <p>If YES, please give date _____ and give details in Section 7</p> <p><i>Please provide relevant reports if available</i></p>	<p>YES</p>	<p>NO</p>
<p>6. Has a Myocardial Perfusion Scan or Stress Echo study been undertaken (or planned)?</p> <p>If YES, please give date _____ and give details in Section 7</p> <p><i>Please provide relevant reports if available</i></p>	<p>YES</p>	<p>NO</p>

Please go to Section 5g

5g Blood Pressure

This section must be filled in for all patients

1. Is today's best systolic pressure reading 180mm Hg or more?	YES	NO
2. Is today's best diastolic pressure reading 100mm Hg or more?	YES	NO
3. 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.	2.	3.

Patient's name		Date of Birth	
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6. General

Please answer all questions in this section. If your answer is 'YES' to any of the questions, please give full details in Section 7 .	YES	NO
1. Is there currently a disability of the spine or limbs, likely to impair control of the vehicle?	YES	NO
2. 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	YES	NO
(a) Is there any evidence the patient has a cancer that causes fatigue or cachexia that affects safe driving?	YES	NO
3. 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 text phone?	YES	NO
4. Is there a history of either renal or hepatic failure?	YES	NO
5. 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
6. Does the patient suffer from narcolepsy/cataplexy? If YES , please give details in Section 7	YES	NO
7. Is there any other Medical Condition , causing excessive 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
8. Does the patient have severe symptomatic respiratory disease causing chronic hypoxia?	YES	NO

Patient's name		Date of Birth	
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<p>9. Does any medication currently taken cause the patient side effects that could affect safe driving? If YES, please provide details of medication</p>	<p>YES</p>	<p>NO</p>
<p>10. Does the patient have any other medical condition that could affect safe driving? If YES, please provide details</p>	<p>YES</p>	<p>NO</p>
<p>7. Please forward copies of relevant hospital notes only if deemed necessary. Please do not send any notes not related to fitness to drive.</p>		
Large empty box for notes		

<p>Patient's name</p>		<p>Date of Birth</p>	
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8. Medical Practitioner Details

To be filled in by Doctor carrying out the examination

Name	Surgery Stamp or GMC Registration Number
Address	
Postcode	
Email address	
Fax number	

Medical Examination Report outcome:

	<ul style="list-style-type: none"> • Fit
	<ul style="list-style-type: none"> • Requires immunisation/vaccinations update on commencement.
	<ul style="list-style-type: none"> • Requires screening to meet requirements of Health & Safety at work legislation.
	<ul style="list-style-type: none"> • Must have Health Examination – appointment arranged.
	<ul style="list-style-type: none"> • Must have Health Examination – appointment to be arranged by Patient.
	<ul style="list-style-type: none"> • Awaiting outcome of correspondence.
	<ul style="list-style-type: none"> • Fit with restrictions – see recommendations.
	<ul style="list-style-type: none"> • Unfit at present – see recommendations.
	<ul style="list-style-type: none"> • Unfit

Recommendations:

I hereby certify that the patient examined is a registered with the surgery named above

Signature of Medical Practitioner	Date of Examination

Patient's name		Date of Birth	

9. Patients Details

To be filled in by patient in the presence of the Medical Practitioner carrying out the examination

Your full name	Date of Birth
Your address	Home phone number
	Work/Daytime number
Postcode	Email address

Please make sure that you have printed your name and date of birth on each page before sending this form with your application.

10 Patient's consent and declaration

This section **MUST** be filled in and must **NOT** be altered in any way.

Consent and Declaration

I authorise my Doctor(s) and Specialist(s) to release report / medical information about my condition, relevant to my fitness to drive, to West Berkshire Council should the Council believe it necessary, to determine a licence application.

I authorise West Berkshire Council to release medical information to my Doctor(s) and or Specialist(s) about the outcome of my case where appropriate.

I declare that I have checked the details I have given on the enclosed questionnaire and that, to the best of my knowledge and belief, they are correct.

"I understand that it is a criminal offence if I make a false declaration to obtain a driving licence and can lead to prosecution."

Signature	Date

Patient's name		Date of Birth	