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).

- Before filling in this form, please read Section B (page 5) of the 'Information and useful notes' booklet (INF4D).
- Please ensure you fully examine the patient as well as taking the patient's history.
- Please answer **all** questions.

D4

Driver and Vehicle Licensing Agency

Patient's weight (kg) | Height (cms)

Details of smoking habits, if any

Number of alcohol units taken each week

Is the urine analysis positive for Glucose? Yes ☐ No ☐ (please tick ✓ appropriate box)

Details of type of specialist(s)/ consultants, including address

Date of last appointment D D M M Y Y | D D M M Y Y | D D M M Y Y

medication	dosage	reason taken

Date when first licensed to drive a lorry D D M M Y Y and/or bus D D M M Y Y

1 Vision (Please see Eyesight notes on page 7 and 8 of leaflet INF4D)

Please tick ✓ the appropriate box(es) — **YES** **NO**

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 ☐ ☐

2. Do corrective lenses have to be worn to achieve this standard? ☐ ☐

If **YES,** is the:-

(a) uncorrected acuity at least 3/60 in the right eye? ☐ ☐

(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) ☐ ☐

(c) correction well tolerated? ☐ ☐

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 Right ☐ Left ☐ **Corrected** (if applicable) Right ☐ Left ☐

4. Is there a defect in the patient's binocular field of vision (central and/or peripheral)? ☐ ☐

5. Is there diplopia? (controlled or uncontrolled)? ☐ ☐

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.

Patient's name ☐ **Date of Birth** ☐

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An executive agency of the Department for **Transport**

2 Nervous System

	YES	NO
1. Has the patient had any form of epileptic attack? If **YES**, please answer questions a–f	☐	☐
(a) Has the patient had more than one attack?	☐	☐
(b) Please give date of first and last attack First attack D D M M Y Y Last attack D D M M Y Y		
(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	☐	☐
(d) If no longer treated, please give date when treatment ended D D M M Y Y		
(e) Has the patient had a brain scan? If **YES,** please state: MRI ☐ Date D D M M Y Y CT ☐ Date D D M M Y Y Please supply reports if available	☐	☐
(f) Has the patient had an EEG? D D M M Y Y If **YES** to any of above, please supply reports if available.	☐	☐
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, 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.	☐	☐
(a) Stroke or TIA *please delete as appropriate*	☐	
If **YES**, please give date D D M M Y Y Has there been a **full** recovery?	☐	☐
Please provide copies of any carotid artery and/or other major cerebral artery imaging reports.		
(b) Sudden and disabling dizziness/vertigo within the last 1 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 or abnormality	☐	
(g) Chronic neurological disorders e.g. Parkinson's disease, Multiple Sclerosis	☐	

3 Diabetes Mellitus

	YES	NO
1. Does the patient have diabetes mellitus? If **NO,** please go to **Section 4** If **YES,** please answer the following questions.	☐	☐
2. Is the diabetes managed by:-		
(a) Insulin? If **YES**, please give date started on insulin D D M M Y Y	☐	☐
(b) If treated with insulin are there at least 3 months of blood glucose readings stored on a memory meter?	☐	☐
(c) Other injectable treatments?	☐	☐
(d) A sulphonylurea or a Glinide?	☐	☐
(e) Oral hypoglycaemic agents and diet? If **YES,** please fill in current medication on the appropriate section on the front of this form	☐	☐
(f) Diet only?	☐	☐
3. (a) Does the patient test blood glucose at least twice every day?	☐	☐
(b) Does the patient test at times relevant to driving?	☐	☐
(c) Does the patient carry fast acting carbohydrate in the vehicle when driving?	☐	☐
(d) Does the patient have a clear understanding of diabetes and the necessary precautions for safe driving?	☐	☐
4. Is there evidence of:-		
(a) Loss of visual field?	☐	☐
(b) Severe peripheral neuropathy, sufficient to impair limb function for safe driving?	☐	☐
5. Is there any evidence of impaired awareness of hypoglycaemia?	☐	☐

Patient's name _____ **Date of birth** _____

6. Has there been laser treatment for retinopathy or intra-vitreal treatment for retinopathy? YES ☐ NO ☐

If **YES**, please give date(s) of treatment

7. Is there a history of hypoglycaemia in the last 12 months requiring the assistance of another person? YES ☐ NO ☐

If **YES** to any of 4–6 above, please give details in **Section 7**

4 Psychiatric Illness

Is there a history of, or evidence of, any of the conditions listed at 1–7 below? YES ☐ NO ☐

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 1.

	YES
1. Significant psychiatric disorder within the past 6 months	☐
2. A psychotic illness within the past 3 years, including psychotic depression	☐
3. Dementia or cognitive impairment	☐
4. Persistent alcohol misuse in the past 12 months	☐
5. Alcohol dependence in the past 3 years	☐
6. Persistent drug misuse in the past 12 months	☐
7. Drug dependence in the past 3 years	☐

5 Cardiac

5A Coronary Artery Disease

Is there a history of, or evidence of, Coronary Artery Disease? YES ☐ NO ☐

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.

1. Acute Coronary Syndromes including Myocardial Infarction? ☐ ☐

   If **YES**, please give date(s) D D M M Y Y

2. Coronary artery by-pass graft surgery? ☐ ☐

   If **YES**, please give date(s) D D M M Y Y

3. Coronary Angioplasty (P.C.I) ☐ ☐

   If **YES**, please give date of most recent intervention D D M M Y Y

4. Has the patient suffered from Angina? ☐ ☐

   If **YES**, please give the date of the last known attack D D M M Y Y

Please go to next Section 5B

Patient's name _____ **Date of birth** _____

5B Cardiac Arrhythmia

	YES	NO
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.

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	☐	☐
2.	Has the arrhythmia been controlled satisfactorily for at least 3 months?	☐	☐
3.	Has an ICD or biventricular pacemaker (CRST-D type) been implanted?	☐	☐
4.	Has a pacemaker been implanted?	☐	☐

If **YES:-**

(a) Please supply date of implantation D D M M Y Y

(b)	Is the patient free of symptoms that caused the device to be fitted?	☐	☐
(c)	Does the patient attend a pacemaker clinic regularly?	☐	☐

Please go to Section 5C

5C Peripheral Arterial Disease (excluding Buerger's Disease) Aortic Aneurysm/Dissection

	YES	NO
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**

1.	**PERIPHERAL ARTERIAL DISEASE (excluding Buerger's Disease)**	☐	☐
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

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 D D M M Y Y

4.	**DISSECTION OF THE AORTA REPAIRED SUCCESSFULLY:** If yes, please provide copies of all reports to include those dealing with any surgical treatment.	☐	☐

Please go to Section 5D

5D Valvular/Congenital Heart Disease

	YES	NO
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.

1.	Is there a history of congenital heart disorder?	☐	☐
2.	Is there a history of heart valve disease?	☐	☐
3.	Is there any history of embolism? (**not** pulmonary embolism)	☐	☐
4.	Does the patient currently have significant symptoms?	☐	☐
5.	Has there been any progression since the last licence application? (if relevant)	☐	☐

Please go to section 5E

Patient's name **Date of birth**

5E Cardiac Other

	YES	NO
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?		
(d) Untreated atrial myxoma		

If YES, please give full details in Section 7 of the form. If NO, go to section 5F

5F Cardiac Investigations

This section must be filled in for all patients

	YES	NO
1. 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?		
Please provide a copy of the ECG report (if available) or comment at Section 7		
2. Has an exercise ECG been undertaken (or planned)?		
If **YES**, please give date D D M M Y Y and give details in **Section 7**		
Please provide relevant reports if available		
3. Has an echocardiogram been undertaken (or planned)?		
(a) If **YES**, please give date D D M M Y Y and give details in **Section 7**		
(b) If undertaken, is/was the left ventricular ejection fraction greater than or equal to 40%?		
Please provide relevant reports if available		
4. Has a coronary angiogram been undertaken (or planned)?		
If **YES**, please give date D D M M Y Y and give details in **Section 7**		
Please provide relevant reports if available		
5. Has a 24 hour ECG tape been undertaken (or planned)?		
If **YES**, please give date D D M M Y Y and give details in **Section 7**		
Please provide relevant reports if available		
6. Has a Myocardial Perfusion Scan or Stress Echo study been undertaken (or planned)?		
If **YES**, please give date D D M M Y Y and give details in **Section 7**		
Please provide relevant reports if available		

Please go to Section 5G

5G Blood Pressure

This section must be filled in for all patients

	YES	NO
1. Is today's best systolic pressure reading 180mm Hg or more?		
2. Is today's best diastolic pressure reading 100mm Hg or more?		
Please give today's reading		
3. Is the patient on anti-hypertensive treatment?		

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

Patient's name **Date of birth**

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?	☐	☐
2. (a) 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		
(b) Is there any evidence the patient has a cancer that causes fatigue or cachexia that affects safe driving?	☐	☐
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 textphone?	☐	☐
4. Does the patient have a history of alcoholic liver disease and/or liver cirrhosis of any origin? If **YES,** please give details in **Section 7**	☐	☐
5. Is there a history of, or evidence of, sleep apnoea syndrome? If **YES**, please provide details	☐	☐
(a) Date of diagnosis D D M M Y Y		
(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		
6. Does the patient suffer from narcolepsy or cataplexy? If **YES,** please give details in **Section 7**	☐	☐
7. Is there any other **Medical Condition** causing excessive daytime sleepiness? If **YES**, please provide details	☐	☐
(a) Diagnosis		
(b) Date of diagnosis D D M M Y Y		
(c) Is it controlled successfully?	☐	☐
(d) If **YES**, please state treatment	(e) Please state period of control	
(f) Date last seen by consultant		
8. Does the patient have severe symptomatic respiratory disease causing chronic hypoxia?	☐	☐
9. Does any medication currently taken cause the patient side effects that could affect safe driving? If **YES**, please provide details of medication and symptoms	☐	☐
10. Does the patient have any other medical condition that could affect safe driving? If **YES**, please provide details	☐	☐

Patient's name **Date of birth**

7 Please forward copies of relevant hospital notes only. PLEASE DO NOT send any notes not related to fitness to drive

Patient's name | **Date of Birth**

Medical Practitioner Details

To be filled in by Doctor carrying out the examination

Please ensure all relevant sections of the form have been filled in as, if not, this will cause the form to be returned for completion.

8 Doctor's details (please print name and address in capital letters)

Name
Address
Telephone
Email address
Fax number

Surgery Stamp or GMC Registration Number

Signature of Medical Practitioner | **Date of Examination**

Patient's Details

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

D4

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

9 Your details

Your full name	
Your address	
Email address	

Date of Birth D D M M Y Y

Home phone number

Work/Daytime number

About your GP/Group Practice

GP/Group name
Address
Phone
Email address
Fax number

10 Patient's consent and declaration

Consent and Declaration

This section **MUST** be filled in and must **NOT** be altered in any way.
Please read the following important information carefully then sign to confirm the statements below.

Important information about Consent

On occasion, as part of the investigation into your fitness to drive, DVLA may require you to undergo a medical examination or some form of practical assessment. In these circumstances, those personnel involved will require your background medical details to undertake an appropriate and adequate assessment. Such personnel might include doctors, orthoptists at eye clinics or paramedical staff at a driving assessment centre. Only information relevant to the assessment of your fitness to drive will be released. In addition, where the circumstances of your case appear exceptional, the relevant medical information would need to be considered by one or more members of the Secretary of State's Honorary Medical Advisory Panels. The membership of these Panels conforms strictly to the principle of confidentiality.

Consent and Declaration

I authorise my Doctor(s) and Specialist(s) to release reports/medical information about my condition relevant to my fitness to drive, to the Secretary of State's medical adviser.

I authorise the Secretary of State to disclose such relevant medical information as may be necessary to the investigation of my fitness to drive, to Doctors, Paramedical staff and Panel members.

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.

Name

Signature **Date**

I authorise the Secretary of State to:

	YES	NO
Inform my Doctor(s) of the outcome of my case	☐	☐
Release reports to my Doctor(s)	☐	☐