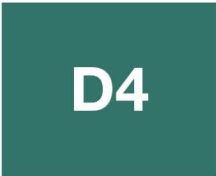




Medical examination report Vision assessment

To be filled in by an optician, optometrist or doctor



1. Please confirm (✓) the scale you are using to express the applicant's visual acuities.

Snellen Snellen expressed as a decimal LogMAR

2. The visual acuity standard for Group 2 driving is at least 6/7.5 in one eye and at least 6/60 in the other.

(a) Please provide uncorrected visual acuities for each eye. Snellen readings with a plus (+) or minus (-) are not acceptable. If 6/7.5, 6/60 standard is not met, the applicant may need further assessment by an optician.

R L Yes No

(b) Are corrective lenses worn for driving? Yes No

If no, go to Q3.

If yes, please provide the visual acuities using the correction worn for driving. Snellen readings with a plus (+) or minus (-) are not acceptable. If 6/7.5, 6/60 standard is not met, the applicant may need further assessment by an optician.

R L

(c) What kind of corrective lenses are worn to meet this standard?

Glasses Contact lenses Both together

(d) If glasses are worn for driving, is the corrective power greater than plus (+)8 dioptres in any meridian of either lens? Yes No

(e) If correction is worn for driving, is it well tolerated? Yes No

If no, please give full details in Q8.

3. Is there a known visual field defect? Yes No

4. Are there any medical conditions which might result in a visual field defect? Yes No

(a) If yes, has a visual field defect been excluded? Yes No

(b) Please provide the condition:

If formal visual field testing is considered necessary, DVLA will commission this at a later date.

5. Is there diplopia? Yes No

(a) Is it controlled? Yes No

Please indicate below and give full details in Q8.

Patch or glasses with frosted glass Glasses with/without prism Other (if other please provide details)

6. Does the applicant report symptoms of any of the following that impairs their ability to drive? Yes No

Please indicate below and give full details in Q8 below.

- (a) Intolerance to glare (causing incapacity rather than discomfort) and/or
- (b) Impaired contrast sensitivity and/or
- (c) Impaired twilight vision

7. Does the applicant have any other ophthalmic condition affecting their visual acuity or visual field? Yes No

If yes, please give full details in Q8 below.

8. Details or additional information

Name of examining doctor, optician or optometrist undertaking vision assessment

I confirm that this report was filled in by me at examination and the applicant's history has been taken into consideration.

Signature of examining doctor, optician or optometrist

Date of signature

Please provide your GOC or GMC number

Doctor, optometrist or optician's stamp

Applicant's full name

Date of birth

Please do not detach this page



1 Neurological disorders

Please tick ✓ the appropriate boxes
Does the applicant have a history or evidence of any neurological disorder (see conditions in questions 1 to 11 below)? Yes No
If no, go to section 2, Diabetes mellitus
If yes, please answer all questions below.

1. Has the applicant had any form of seizure? Yes No
(a) Has the applicant had more than one seizure episode?
(b) Please give date of first and last episode.
First episode
Last episode
(c) Is the applicant currently on anti-seizure medication?
(d) If no longer treated, when did treatment end?
(e) Has the applicant had a brain scan?
If yes, please give details in section 9, page 6.

2. Has the applicant experienced any dissociative/functional seizures? Yes No
(a) If yes, please give date of most recent episode.
(b) If yes, have any of these episode(s) occurred or are they considered likely to occur whilst driving?

3. Stroke or TIA? Yes No
If yes, give date.
(a) Has there been a **full** recovery?
(b) Has a carotid ultrasound been undertaken?
(c) If yes, was the carotid artery stenosis >50% in either carotid artery?
(d) Is there a history of multiple strokes/TIAs?

4. Sudden and disabling dizziness or vertigo within the last year with a liability to recur?

5. Subarachnoid haemorrhage (non-traumatic)?

6. Significant head injury within the last 10 years?

7. Any form of brain tumour?

8. Other intracranial pathology?

9. Chronic neurological disorder(s)?

10. Parkinson's disease?

11. Blackout, impaired consciousness or loss of awareness within the last 5 years?

2 Diabetes mellitus

Does the applicant have diabetes mellitus? Yes No
If no, go to section 3, Cardiac
If yes, please answer all questions below.

1. Is the diabetes treated by: Yes No
(a) Insulin?
If no, go to 1c
If yes, please give date started on insulin.
(b) Are there at least 6 continuous weeks of blood glucose readings stored on a memory meter or meters?
If no, please give details in section 9, page 6.
(c) Other injectable treatments?
(d) A Sulphonylurea or a Glinide?
(e) Oral hypoglycaemic agents and diet?
(f) Diet only?

2. (a) Does the applicant test blood glucose at least twice every day? Yes No
(b) Does the applicant test at times relevant to driving (no more than 2 hours before the start of the first journey and every 2 hours whilst driving)?
(c) Does the applicant keep fast-acting carbohydrate within easy reach whilst driving?
(d) Does the applicant have a clear understanding of diabetes and the necessary precautions for safe driving?

3. (a) Has the applicant ever had a hypoglycaemic episode? Yes No
(b) Is there full awareness of hypoglycaemia?

4. Is there a history of hypoglycaemia in the last 12 months requiring the assistance of another person? Yes No
If yes, please give details and dates below.

5. Has there been laser treatment or intra-vitreous treatment for retinopathy? Yes No
If yes, please give most recent date of treatment.

Applicant's full name

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3 Cardiac

a Coronary artery disease

Is there a history or evidence of coronary artery disease? Yes No

If no, go to section 3b, Cardiac arrhythmia

If yes, please answer all questions below.

1. Has the applicant ever had an episode of angina? Yes No

If yes, please give the date of the last known attack.

2. Acute coronary syndrome including myocardial infarction? Yes No

If yes, please give date.

3. Coronary angioplasty (PCI)? Yes No

If yes, please give date of most recent intervention.

4. Coronary artery bypass graft surgery? Yes No

If yes, please give date.

5. If yes to any of the above, are there any physical health problems or disabilities (e.g. mobility, arthritis or COPD) that would make the applicant unable to undertake 9 minutes of the standard Bruce Protocol ETT? Please give details below. Yes No

b Cardiac arrhythmia

Is there a history or evidence of cardiac arrhythmia? Yes No

If no, go to section 3c, Peripheral arterial disease

If yes, please answer all questions below.

1. Has there been a significant disturbance of cardiac rhythm causing/likely to cause incapacity in the last 5 years? Yes No

2. Has the arrhythmia been controlled satisfactorily for at least 3 months? Yes No

3. Has an ICD (Implanted Cardiac Defibrillator) or biventricular pacemaker with defibrillator/ cardiac resynchronisation therapy defibrillator (CRT-D type) been implanted? Yes No

4. Has a pacemaker or a biventricular pacemaker/ cardiac resynchronisation therapy pacemaker (CRT-P type) been implanted? Yes No

If yes:

(a) Please give date of implantation.

(b) Is the applicant free of the symptoms that caused the device to be fitted?

(c) Does the applicant attend a pacemaker clinic regularly?

c Peripheral arterial disease (excluding Buerger's disease) aortic aneurysm/dissection

Is there a history or evidence of peripheral arterial disease (excluding Buerger's disease), aortic aneurysm or dissection? Yes No

If no, go to section 3d, Valvular/congenital heart disease

If yes, please answer all questions below.

1. Peripheral arterial disease? (excluding Buerger's disease) Yes No

2. Does the applicant have claudication? Yes No

 If yes, would the applicant be able to undertake 9 minutes of the standard Bruce Protocol ETT?

3. Aortic aneurysm? Yes No
 If yes:

(a) Site of aneurysm: Thoracic
 Abdominal

(b) Has it been repaired successfully?

(c) Please provide latest transverse aortic diameter measurement and date obtained using measurement and date boxes.

cm

4. (a) Dissection of aorta? Yes No

(b) If yes, has the dissection been successfully repaired?

If yes to 4a, please provide copies of all reports including those dealing with any surgical treatment.

5. Is there a history of Marfan's disease? Yes No

(a) If yes, are there any associated risk factors*?

*risk factors include –

- family history of aortic dissection
- greater than 3mm per year increase than aneurysm diameter
- pregnancy

d Valvular/congenital heart disease

Is there a history or evidence of valvular or congenital heart disease? Yes No

If no, go to section 3e, Cardiac other

If yes, please answer all questions below.

1. Is there a history of congenital heart disease? Yes No

2. Is there a history of heart valve disease? Yes No

(a) If yes, are they symptomatic?

3. Is there a history of aortic stenosis? Yes No
 If yes, please provide relevant reports (including echocardiogram).

4. Has there been any progression (either clinically or on scans etc) since the last licence application? Yes No

Applicant's full name

Date of birth

e Cardiac other

Is there a history or evidence of heart failure? Yes No

If no, go to section 3f, Cardiac channelopathies

If yes, please answer all questions below.

1. Please provide the NYHA class, if known.

2. Established cardiomyopathy? Yes No

If yes, please give details in section 9, page 6.

3. Has a left ventricular assist device (LVAD) or other cardiac assist device been implanted? Yes No

4. A heart or heart/lung transplant? Yes No

5. Evidence or history of pulmonary arterial hypertension? Yes No

f Cardiac channelopathies

Is there a history or evidence of the following conditions? Yes No

If no, go to section 3g, Blood pressure

1. Brugada syndrome? Yes No

2. Long QT syndrome? Yes No
If yes to either, please give details in section 9, page 6.

g Blood pressure

All questions must be answered.

If resting blood pressure is 180 mm/Hg systolic or more and/or 100mm/Hg diastolic or more, please take a further 2 readings at least 5 minutes apart and record the best of the 3 readings in the box provided.

1. Please record today's best resting blood pressure reading. /

2. Is the applicant on anti-hypertensive treatment? Yes No
If yes, please provide three previous readings with dates if available.

<input type="text"/>	/	<input type="text"/>
<input type="text"/>	/	<input type="text"/>
<input type="text"/>	/	<input type="text"/>

D	D	M	M	Y	Y
D	D	M	M	Y	Y
D	D	M	M	Y	Y

h Cardiac investigations

Have any cardiac investigations been undertaken or planned? Yes No

If no, go to section 4, Psychiatric illness

If yes, please answer questions 1 to 5.

1. Is there a history of the following: Yes No

(a) left bundle branch block (LBBB)?

(b) right bundle branch block (RBBB)?

(c) paced rhythm?

If yes to (a), (b) or (c), please give details in section 9, page 6.

Note: If yes to questions 2 to 5, please give dates in the boxes provided, give details in section 9, page 6.

2. Has an exercise ECG been undertaken (or planned)? Yes No

3. Has an echocardiogram been undertaken (or planned)? Yes No

(a) If undertaken, is or was the left ejection fraction greater than or equal to 40%?

4. Has a coronary angiogram been undertaken (or planned)? Yes No

5. Has a myocardial perfusion scan, stress echo study or cardiac MRI been undertaken (or planned)? Yes No

4 Psychiatric illness

Is there any significant mental illness or cognitive impairment likely to affect safe driving? Yes No

If no, go to section 5, Substance misuse

If yes, please answer all questions below.

1. Significant psychiatric disorder within the past 6 months? If yes, please confirm condition. Yes No

2. Psychosis or hypomania/mania within the past 12 months, including psychotic depression? Yes No

3. (a) Dementia or cognitive impairment? Yes No
(b) Are there concerns which have resulted in ongoing investigations for such possible diagnoses?

5 Substance misuse

Is there a history of drug/alcohol misuse or dependence? Yes No

If no, go to section 6, Sleep disorders

If yes, please answer all questions below.

1. Is there a history of an alcohol use disorder (sufficient to cause significant physical, mental or social consequences) in the past 10 years? Yes No

2. If there is a history of an alcohol use disorder, has this been associated with any of the following features which indicate a physiological dependence on alcohol: Yes No

(a) Required medical assisted withdrawal?

Date treatment ended:

(b) Alcohol withdrawal seizure?

Date of last event:

3. Based on their clinical record and/or account of drinking provided to you, is their alcohol consumption: Yes No

(a) Abstinent? Yes No Don't know

If yes, for how long:

(b) Controlled? Yes No Don't know

If yes, for how long:

4. Use of illegal drugs or other substances, or misuse of prescription medication in the last 6 years? Yes No

(a) If yes, the type of substance misused?

(b) Is it controlled?

(c) Has the applicant undertaken an opiate treatment programme?

If yes, give date started

Applicant's full name

Date of birth

6 Sleep disorders

1. Is there a history or evidence of Obstructive Sleep Apnoea Syndrome or any other medical condition causing excessive sleepiness? Yes No

If no, go to section 7, Other medical conditions.

If yes, please give diagnosis and answer all questions below.

- a) If Obstructive Sleep Apnoea Syndrome, please indicate the severity:

Mild (AHI <15)

Moderate (AHI 15 - 29)

Severe (AHI >29)

Not known

If another measurement other than AHI is used, it must be one that is recognised in clinical practice as equivalent to AHI. DVLA does not prescribe different measurements as this is a clinical issue. Please give details in section 9 page 6, Further details.

- b) Please answer questions (i) to (iv) for **all** sleep conditions.

(i) Date of diagnosis: Yes No

(ii) Is it controlled successfully?

(iii) Is applicant compliant with treatment?

(iv) Date of last review.

7 Other medical conditions

1. Is there a history or evidence of narcolepsy? Yes No

2. Is there any impairment resulting from either a physical or non-physical medical condition which is likely to affect the ability to control a vehicle? Yes No

If yes, please provide information in section 9, page 6.

3. Is there a history of bronchogenic carcinoma or other malignant tumour with a significant liability to metastasise cerebrally? Yes No

4. Is there any illness that may cause significant fatigue or cachexia that affects safe driving? Yes No

5. Does the applicant have a history of liver disease of any origin? Yes No

 If yes, is this the result of alcohol misuse?
 If yes, please give details in section 9, page 6.

6. Is there a history of renal failure? Yes No

 If yes, please give details in section 9, page 6.

7. Does the applicant have severe symptomatic respiratory disease causing chronic hypoxia? Yes No

8. Does the applicant have any other medical condition that could affect safe driving? Yes No

 If yes, please provide details in section 9, page 6.

8 Medication

Is the applicant currently prescribed any of the following medication:

- | | Yes | No |
|---------------------------------|--------------------------|--------------------------|
| (a) Anti-seizure? | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Clozapine? | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) Sulphonylurea or a Glinide? | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) Insulin? | <input type="checkbox"/> | <input type="checkbox"/> |

9 Further details

Do not send any notes not related to fitness to drive.

Use the space below to provide any additional information.

Applicant's full name

Date of birth

The applicant must fill in this page

Applicant's declaration

You **must** fill in this section and **must not** alter it in any way.

Please read the following important information carefully then sign to confirm the statements below.

Important information about fitness to drive

As part of the enquiries into your fitness to drive, we (DVLA) may need you to have a medical examination and/or some form of practical assessment. If we do, the individuals involved in these will need your background medical details to carry out an appropriate assessment.

These individuals may include doctors, orthoptists at eye clinics or paramedical staff at a driving assessment centre. We will only share information relevant to the medical assessment of your fitness to drive.

Also, where the circumstances of your case appear to suggest the need for this, the relevant medical information may need to be considered by one or more of the members of the Secretary of State's Honorary Medical Advisory Panels. The membership of these Panels conforms strictly to the principle of confidentiality.

For information about how we process your data, your rights and who to contact, see our privacy notice at www.gov.uk/dvla/privacy-policy

Declaration

I authorise my doctor, specialist or appropriate healthcare professional to disclose medical information or reports about my health condition to the DVLA, on behalf of the Secretary of State for Transport, that is relevant to my fitness to drive.

I understand that the doctor that I authorise, may pass this authorisation to another registered healthcare professional, who will be able to provide information about my medical condition that is relevant to my fitness to drive.

I understand that the Secretary of State may disclose such relevant medical information as is necessary to the investigation of my fitness to drive to doctors and other healthcare professionals such as orthoptists, paramedical staff and the Secretary of State for Transport's Honorary Medical Advisory 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 correspond with medical professionals via electronic channels (email)

Yes No

Checklist

- Have you signed and dated the declaration? **Yes**
- Have you checked that the optician, optometrist or doctor has filled in all parts of the report and all relevant hospital notes have been enclosed? **Yes**

Important

This report is valid for 4 months from the date the doctor, optician or optometrist signs it.

Please return it together with your application form.