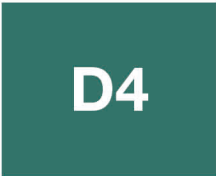




Medical examination report Vision assessment

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

D	D	M	M	Y	Y
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Please provide your GOC or GMC number

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Doctor, optometrist or optician's stamp

Applicant's full name

Date of birth

D	D	M	M	Y	Y
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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)?
If no, go to section 2, Diabetes mellitus
If yes, please answer all questions below.

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

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

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

4. Sudden and disabling dizziness or vertigo within the last year with a liability to recur?	<input type="checkbox"/>	<input type="checkbox"/>
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5. Subarachnoid haemorrhage (non-traumatic)?	<input type="checkbox"/>	<input type="checkbox"/>
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6. Significant head injury within the last 10 years?	<input type="checkbox"/>	<input type="checkbox"/>
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7. Any form of brain tumour?	<input type="checkbox"/>	<input type="checkbox"/>
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8. Other intracranial pathology?	<input type="checkbox"/>	<input type="checkbox"/>
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9. Chronic neurological disorder(s)?	<input type="checkbox"/>	<input type="checkbox"/>
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10. Parkinson's disease?	<input type="checkbox"/>	<input type="checkbox"/>
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11. Blackout, impaired consciousness or loss of awareness within the last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>
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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?	<input type="checkbox"/>	<input type="checkbox"/>
If no, go to 1c		
If yes, please give date started on insulin.	DDMMYY	
(b) Are there at least 4 continuous weeks of glucose readings stored on a memory meter or meters? If no, please give details in section 9, page 6.	<input type="checkbox"/>	<input type="checkbox"/>
(c) Other injectable treatments?	<input type="checkbox"/>	<input type="checkbox"/>
(d) A Sulphonylurea or a Glinide?	<input type="checkbox"/>	<input type="checkbox"/>
(e) Oral hypoglycaemic agents and diet?	<input type="checkbox"/>	<input type="checkbox"/>
(f) Diet only?	<input type="checkbox"/>	<input type="checkbox"/>

2. (a) Does the applicant monitor their glucose level using continuous glucose monitoring (CGM)?	Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>
(b) If yes, is the continuous glucose monitoring (CGM) device approved for non-adjunctive use?	<input type="checkbox"/>	<input type="checkbox"/>
(c) Does the applicant carry a finger prick monitoring device?	<input type="checkbox"/>	<input type="checkbox"/>
(d) Does the applicant test glucose at least twice every day?	<input type="checkbox"/>	<input type="checkbox"/>
(e) Does the applicant test glucose at times relevant to driving? (Within 2 hours of starting their first journey of the day and continuing to check at least every 2 hours during their journey. There must be no more than 2 hours between glucose checks at any time during their journey).	<input type="checkbox"/>	<input type="checkbox"/>
(f) Does the applicant keep fast-acting carbohydrate within easy reach whilst driving?	<input type="checkbox"/>	<input type="checkbox"/>
(g) Does the applicant have a clear understanding of diabetes and the necessary precautions for safe driving?	<input type="checkbox"/>	<input type="checkbox"/>

3. (a) Has the applicant ever had a hypoglycaemic episode?	Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>
(b) Is there full awareness of hypoglycaemia?	<input type="checkbox"/>	<input type="checkbox"/>

4. Is there a history of hypoglycaemia in the last 12 months requiring the assistance of another person? If yes, please give details and dates below.	Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>
[Text area for details]		
	DDMMYY	DDMMYY
	DDMMYY	

5. Has there been laser treatment or intra-vitreous treatment for retinopathy?	Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please give most recent date of treatment.	DDMMYY	

Applicant's full name	[Grid for name]	Date of birth	DDMMYY
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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

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? Yes No

(iii) Is applicant compliant with treatment? Yes No

(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 any illness that may cause significant fatigue or cachexia that affects safe driving? Yes No

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

If yes, is this the result of alcohol misuse? Yes No

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

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

If yes, please give details in section 9, page 6. Yes No

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

7. 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.