Medical Examination Report

To be completed by the Doctor (please use black ink)

D4

- Before completing this form, please read Section B (page 6) of the INF4D – 'Information and useful notes' booklet, supplied with this report.
- Please answer **all** questions

Driver and Vehicle Licensing Agency

Please give patient's weight (kg/st) _____ height (cms/ft) _____

Please give details of smoking habits, if any _____

Please give number of alcohol units taken each week _____

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

Details of specialist(s)/ consultants, including address	1	2	3
Specialty			
Date last seen			

Current medication including exact dosage and reason for each treatment _____

Date when first licensed to drive a lorry _____ and/or bus _____

1 Vision (Please see Eyesight notes on page 8 and 9 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 **Corrected (if applicable)**

Right _____ Left _____ Right _____ Left _____

4. **Is there a defect in his/her binocular field of vision** (central and/or peripheral)? ☐ ☐

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

6. Does the applicant 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.

Applicant's name _____ **DOB** _____

CUSTOMER SERVICE EXCELLENCE

An executive agency of the Department for Transport

2 Nervous System

1. Has the applicant had any form of epileptic attack? **YES** ☐ **NO** ☐

(a) If **Yes,** please give date of last attack D D M M Y Y

(b) If treated, please give date when treatment ceased D D M M Y Y

(c) Is the applicant currently on anti-epileptic medication? ☐ ☐

If **YES,** please complete current medication on the appropriate section on the front of this form

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. Does the applicant suffer from narcolepsy/cataplexy? ☐ ☐
If **YES,** please give details in **Section 7**

4. Is there a history of, or evidence of any of the conditions listed at a–h below? **YES** ☐ **NO** ☐

If NO, go to **Section 3.**

If YES, please tick the relevant box(es) and give dates and full details at **Section 7.**

(a) Stroke / TIA *please delete as appropriate* ☐

(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 ☐

(g) Chronic neurological disorders e.g. Parkinson's disease, Multiple Sclerosis ☐

(h) Dementia or cognitive impairment ☐

3 Diabetes Mellitus

1. Does the applicant have diabetes mellitus? **YES** ☐ **NO** ☐

If **NO,** please proceed 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) Oral hypoglycaemic agents and diet? ☐ ☐
If **YES,** please complete current medication on the appropriate section on the front of this form

(c) Diet only? ☐ ☐

3. Does the applicant test blood glucose at least twice every day? ☐ ☐

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? ☐ ☐

5. Has there been laser treatment for retinopathy? ☐ ☐
If **YES,** please give date(s) of treatment

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**

Applicant's name **DOB**

4 Psychiatric Illness

Is there a history of, or evidence of any of the conditions listed at 1–6 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. If applicant remains under specialist clinic(s) ensure details are completed 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.	Persistent alcohol misuse in the past 12 months	☐
4.	Alcohol dependency in the past 3 years	☐
5.	Persistent drug misuse in the past 12 months	☐
6.	Drug dependency in the past 3 years	☐

N.B. Please enclose relevant hospital notes with reference to this condition

5 Cardiac

Please follow the instructions in all Sections (5A–5G) giving details as required in Section 7 and enclose hospital notes relevant to this condition.

NB. If applicant remains under specialist cardiac clinic(s) ensure details are completed on page 5.

5A Coronary Artery Disease

Is there a history of, or evidence of, coronary artery disease? YES ☐ NO ☐

If **NO,** proceed to **Section 5B**

If **YES** please answer all questions below and give details at **Section 7** of the form.

1.	Acute Coronary Syndrome including Myocardial Infarction?	☐	☐
	If **Yes,** please give date(s) D D M M Y Y		
2.	Coronary artery by-pass graft?	☐	☐
	If **Yes,** please give date(s) D D M M Y Y		
3.	Coronary Angioplasty (P.C.I)	☐	☐
	If **Yes,** please give date(s) D D M M Y Y		
4.	Has the applicant suffered from Angina?	☐	☐
	If **Yes,** please give the date of the last attack D D M M Y Y		

Please proceed to next Section 5B

Applicant's name _____ **DOB** _____

5B Cardiac Arrhythmia

	YES	NO
Is there a history of, or evidence of, cardiac arrhythmia?	☐	☐

If **NO,** proceed to **Section 5C**

If **YES** please answer all questions below and give details at **Section 7** of the form.

1.	Has the applicant had a **significant** documented disturbance of cardiac rhythm within the past 5 years?	☐	☐
2.	Has the arrhythmia been controlled satisfactorily for at least 3 months?	☐	☐
3.	Has a cardiac defibrillator device (I.C.D) been implanted?	☐	☐
4.	Has a pacemaker been implanted?	☐	☐
	If **YES:-**		
	(a) Has the pacemaker been implanted for at least 6 weeks?	☐	☐
	(b) Since implantation of the pacemaker, is the applicant now symptom free as a result?	☐	☐
	(c) Does the applicant attend a pacemaker clinic regularly?	☐	☐

Please proceed to next Section 5C

5C Peripheral Arterial Disease

		YES	NO
1.	Is there a history or evidence of ANY of the below:	☐	☐

If **YES** please **tick** ✓ ALL relevant boxes below, and give details at **Section 7** of the form.

	YES	NO
PERIPHERAL ARTERIAL DISEASE	☐	☐
AORTIC ANEURYSM		
IF YES:		
(a) Site of Aneurysm: **Thoracic** ☐ **Abdominal** ☐		
(b) Has it been repaired successfully?	☐	☐
(c) Is the transverse diameter more than 5cms?	☐	☐
DISSECTION OF THE AORTA		
IF YES:		
(d) Has it been repaired successfully?	☐	☐

Please proceed to next Section 5D

5D Valvular/Congenital Heart Disease

	YES	NO
Is there a history of, or evidence, of valvular/congenital heart disease?	☐	☐

If **NO,** proceed to **Section 5E**

If **YES** please answer all questions below and give details at **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 applicant currently have significant symptoms?	☐	☐
5.	Has there been any progression since the last licence application? (if relevant)	☐	☐

Please proceed to next section 5E

Applicant's name _____ **DOB** _____

5E Cardiomyopathy

Does the applicant have a history of ANY of the following conditions: YES ☐ NO ☐

(a) a history of, or evidence of heart failure?

(b) established cardiomyopathy?

(c) a heart or heart/lung transplant?

If YES to any part of the above, please give full details in Section 7 of the form. If NO, proceed to next section 5F.

5F Cardiac Investigations

YES NO

This section must be completed for all applicants.

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? ☐ ☐

2. Has an exercise ECG been undertaken (or planned)? ☐ ☐

If **YES,** please give date and give details in **Section 7** D D M M Y Y

Sight/copy of the exercise test result/report (if done in the last 3 years) would be helpful

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%? ☐ ☐

Sight/copy of the echocardiogram result/report would be useful

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**

Sight/copy of the angiogram result/report would be useful

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**

Sight/copy of the 24 hour tape result/report would be useful

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**

Sight/copy of the scan result/report would be useful

Please proceed to Section 5G

5G Blood Pressure

This section must be completed for all applicants

YES NO

1. Is today's resting systolic pressure 180mm Hg or greater? ☐ ☐

2. Is today's resting diastolic pressure 100mm Hg or greater? ☐ ☐

3. Is the applicant on anti-hypertensive treatment? ☐ ☐

If YES, to any of the above, please supply today's reading and three previous readings and dates

Applicant's name **DOB**

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. 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
3. Is the applicant profoundly deaf?	☐	☐
If **YES**, is he/she able to communicate in the event of an emergency by speech or by using a device, e.g. a MINICOM/ text phone?	☐	☐
4. Is there a history of either renal or hepatic failure?	☐	☐
5. Does the applicant have sleep apnoea syndrome?	☐	☐

If **YES**, please supply 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

	YES	NO
6. Is there any other **Medical Condition**, causing excessive daytime sleepiness?	☐	☐

If **YES**, please supply 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

	YES	NO
7. Does the applicant have severe symptomatic respiratory disease causing chronic hypoxia?	☐	☐
8. Does any medication currently taken cause the applicant side effects that could affect safe driving?	☐	☐

If **YES**, please supply details of medication

	YES	NO
9. Does the applicant have any other medical condition that could affect safe driving?	☐	☐

If **YES**, please supply details

Applicant's name **DOB**

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

Applicant's name **DOB**

8 Applicant's consent and declaration

Consent and Declaration

This section **MUST** be completed and must **NOT** be altered in any way.
Please read the following important information carefully then sign 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 report/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, and to inform my doctor(s) of the outcome of the 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**

Applicant's Details

To be completed 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
E-mail address

Date of Birth D D M M Y Y

Home telephone number

Work/Daytime number

About your GP/Group Practice

GP/Group name
Address
Telephone
E-mail address
Fax number

Medical Practitioner Details

To be completed by Doctor carrying out the examination

10 Doctor's details

Name
Address
E-mail address
Fax number

Surgery Stamp

Signature of Medical Practitioner

Date