





# 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.

R  L

Yes No

(b) Are corrective lenses worn for driving?

**If No, go to Q3.**

If Yes, please provide the visual acuities using the correction worn for driving.

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 Q7.

3. Is there a history of any medical condition that may affect the applicant's binocular field of vision (central and/or peripheral)? Yes No

If Yes, please give full details below.

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

4. Is there diplopia? Yes No

(a) Is it controlled?

Please indicate below and give full details in Q7.

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

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

Please indicate below and give full details in Q7 below.

(a) Intolerance to glare and/or

(b) Impaired contrast sensitivity and/or

(c) Impaired twilight vision

6. Does the applicant have any other ophthalmic condition? Yes No

If Yes, please give full details in Q7 below.

7. Details or additional information

Name of examining doctor or optician undertaking vision assessment


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

Signature of examining doctor or optician

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**



### 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 and enclose relevant hospital notes.

1. Has the applicant suffered from 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 and enclose relevant hospital notes.

1. Has there been a significant disturbance of cardiac rhythm? (e.g. sinoatrial disease, significant atrio-ventricular conduction defect, atrial flutter or fibrillation, narrow or broad complex tachycardia) 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?

Applicant's full name

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Date of birth

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#### 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 and enclose relevant hospital notes.

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. Dissection of the aorta repaired successfully? Yes No

If Yes, please provide copies of all reports including those dealing with any surgical treatment.

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

If Yes, please provide relevant hospital notes.

#### 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, answer all questions below and provide relevant hospital notes.

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

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

3. Is there a history of aortic stenosis? Yes No

If Yes, please provide relevant reports (including echocardiogram).

4. Is there any history of embolism? (not pulmonary embolism) Yes No

5. Does the applicant currently have significant symptoms? Yes No

6. Has there been any progression since the last licence application (if relevant)? Yes No



## 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 7, Further details.

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

(i) Date of diagnosis:       Yes  No

(ii) Is it controlled successfully?  Yes  No

(iii) If Yes, please state treatment.

(iv) Is applicant compliant with treatment? Yes  No

(v) Please state period of control:

years  months

(vi) Date of last review:

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

## 7 Other medical conditions

1. Is there currently any functional impairment that is likely to affect control of the vehicle? Yes  No

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

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

4. Is the applicant profoundly deaf? Yes  No   
 If Yes, is the applicant able to communicate in the event of an emergency by speech Yes  No   
 or by using a device, e.g. a textphone?  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?  Yes  No

If Yes, please give details in section 9, page 7.

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

If Yes, please give details in section 9, page 7.

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

8. Does any medication currently taken cause the applicant side effects that could affect safe driving? Yes  No

If Yes, please fill in section 8, Medication and give symptoms in section 9, page 7.

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

If Yes, please provide details in section 9, page 7.

## 8 Medication

Please provide details of all current medication including eye drops (continue on a separate sheet if necessary).

Medication	Dosage
Reason for taking:	
Date started: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	

Medication	Dosage
Reason for taking:	
Date started: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	

Medication	Dosage
Reason for taking:	
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Medication	Dosage
Reason for taking:	
Date started: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	

Applicant's full name

Date of birth



## The applicant must complete 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 investigation into your fitness to drive, we (DVLA) may require you to have a medical examination or some form of practical assessment. If we do, the people involved will need your medical details to carry out an appropriate assessment. These may include doctors, orthoptists at eye clinics or paramedical staff at a driving assessment centre. We will only release information relevant to the medical assessment of your fitness to drive. Also, 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. Panel members must adhere strictly to the principle of confidentiality.

#### Declaration

I authorise my doctor and specialist to release reports and information about my condition which is relevant to my fitness to drive, to the Secretary of State's medical adviser.

I understand that the Secretary of State may disclose relevant medical information that is necessary to investigate 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 doctors about the outcome of my case	<input type="checkbox"/>	<input type="checkbox"/>
release reports to my doctor(s)	<input type="checkbox"/>	<input type="checkbox"/>

Contact me about my application by:

	Yes	No
email	<input type="checkbox"/>	<input type="checkbox"/>
sms(text message)	<input type="checkbox"/>	<input type="checkbox"/>

**(Please note: DVLA will continue to contact you by post if you do not wish to be contacted by email or text.)**

Checklist	Yes
• Have you signed and dated the declaration?	<input type="checkbox"/>
• Have you checked that the optician or doctor has filled in all parts of the report and all relevant hospital notes have been enclosed?	<input type="checkbox"/>

#### 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.**