Driver and Vehicle Licensing Agency

# Medical Examination Report

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

**D4 Online**

- 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

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 sample taken, 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

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

| | YES | NO |
|---|---|---|
| **1. Does the applicant have diabetes mellitus?** | ☐ | ☐ |
| 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? | ☐ | ☐ |
| (c) Diet only? | ☐ | ☐ |
| **3.** Does the patient 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 | ☐ |

## 5 Cardiac

**Please follow the instructions in all Sections (5A–5G) giving details as required at Section 7.**

**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.** | 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 (with or without stent)? | | ☐ ☐ |
| | 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

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

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 been implanted? ☐ ☐

**4.** Has a pacemaker been implanted? ☐ ☐

If **YES:-**

a) Has the pacemaker been implanted for at least 6 weeks? ☐ ☐

b) Since implantation, is the patient now symptom free from this condition? ☐ ☐

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

**Please proceed to next Section 5C**

## 5C Peripheral Arterial Disease

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

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:**

a. Has it been repaired successfully: ☐ ☐

**Please proceed to next Section 5D**

## 5D Valvular/Congenital Heart Disease

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

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

| | YES | NO |
|---|---|---|
| **Does the applicant 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? | ☐ | ☐ |

**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

**This section must be completed for all applicants.**

| | YES | NO |
|---|---|---|
| **1.** Has a resting ECG been undertaken? | ☐ | ☐ |
| If **YES,** does it show:- | | |
| (a) pathological Q waves? | ☐ | ☐ |
| (b) left 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 useful* | | |
| **3.** Has an echocardiogram 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 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 imaging scan 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** ☐

**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 | | |
| **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**, has it been controlled successfully? | ☐ | ☐ |
| **6.** | Is there any other **Medical Condition**, causing excessive daytime sleepiness? | ☐ | ☐ |

**6a.** If **YES**, please give full details below.

| | | 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 which impair his/her safe driving? | ☐ | ☐ |

**Applicant's name** **DOB**

## 7 Please forward copies of all relevant hospital notes if available

**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 reports to the Secretary of State's medical adviser about my condition.**

**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 release to my doctor(s) details of the outcome of my case and any relevant medical information.**

**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.**

**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 |

# Medical Practitioner Details

To be completed by Doctor carrying out the examination

## 10 Doctor's details

| |
|---|
| Name |
| Address |
| |
| |
| |
| E-mail address |

**Surgery Stamp**

**Signature of Medical Practitioner**

**Date**