



Medical examination report Vision assessment



To be filled in by a doctor or optician/optometrist

Doctors – You MUST read the notes in the INF4D leaflet so that you can decide whether you are able to fully complete the vision assessment.
Please check the applicant's identity before you proceed.

The visual acuity, as measured by the 6 metre Snellen chart, must be at least 6/7.5 (decimal Snellen equivalent 0.8) in the better eye and at least Snellen 6/60 (decimal Snellen equivalent 0.1) in the other eye. Corrective lenses may be worn to achieve this standard. A LogMAR reading is acceptable.

If correction is needed to meet the eyesight standard for driving, ALL questions must be answered. If correction is NOT needed, questions 4 and 5 can be ignored.

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

Snellen Snellen expressed as a decimal
LogMAR

2. Please state the visual acuity of each eye.

Please convert any 3 metre readings to the 6 metre equivalent.

Uncorrected		Corrected (using the prescription worn for driving)	
R	L	R	L

3. Please give the best binocular acuity (with corrective lenses if worn for driving).

4. If **glasses** were worn, was the distance spectacle prescription of either lens used of a corrective power greater than plus 8 (+8) dioptres? **YES NO**

5. If a correction is worn for driving, is it well tolerated?

If you answer Yes to ANY of the following, give details in the box provided.

6. Is there a history of any medical condition that may affect the applicant's binocular field of vision (central and/or peripheral)?

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

7. Is there diplopia?
(a) Is it controlled?
If **Yes**, please ensure you give full details in the box provided

8. Is there any reason to believe that there is impairment of contrast sensitivity or intolerance to glare?

9. Does the applicant have any other ophthalmic condition?

Details

Date of examination (see INF4D)

Name (print)

Signature

Date of signature

Please provide your GOC, HPC or GMC number

Doctor/optometrist/optician's stamp

Applicant's full name

Date of birth

Please do not detach this page





Medical examination report

Medical assessment

Must be filled in by a doctor

- Please check the applicant's identity before you proceed.
- Please ensure you fully examine the applicant as well as taking the applicant's history.
- **Please answer all questions**, and read the notes in the INF4D leaflet (Information and useful notes) to help you complete this form

D4

1 Nervous system

- Please tick ✓ the appropriate box(es) YES NO
1. Has the applicant had any form of seizure? YES NO
If **NO**, please go to **question 2**
If **YES**, please answer questions a-f
- (a) Has the applicant had more than one attack? YES NO
- (b) Please give date of first and last attack
- First attack
- Last attack
- (c) Is the applicant currently on anti-epileptic medication? YES NO
If **YES**, please fill in current medication in **section 8**
- (d) If no longer treated, please give date when treatment ended
- (e) Has the applicant had a brain scan? YES NO
If **YES**, please give details in section 6
- (f) Has the applicant had an EEG? YES NO
If **YES** to any of above, please supply reports if available.
2. Is there a history of blackout or impaired consciousness within the last 5 years? YES NO
If **YES**, please give date(s) and details in **section 6**
3. Does the applicant suffer from narcolepsy or cataplexy? YES NO
If **YES**, please give date(s) and details in **section 6**
4. Is there a history of, or evidence of **ANY** conditions listed at a-h? YES NO
If **NO**, go to **section 2**
If **YES**, please give full details at **section 6** and supply relevant reports
- (a) Stroke or TIA YES NO
If **YES**, please give date
- Has there been a **full** recovery? YES NO
- Has a carotid ultra sound been undertaken? YES NO
- (b) Sudden and disabling dizziness/vertigo within the last year with a liability to recur YES NO
- (c) Subarachnoid haemorrhage YES NO
- (d) Serious traumatic brain injury within the last 10 years YES NO
- (e) Any form of brain tumour YES NO
- (f) Other brain surgery or abnormality YES NO
- (g) Chronic neurological disorders YES NO
- (h) Parkinson's disease YES NO

2 Diabetes mellitus

- YES NO
1. Does the applicant have diabetes mellitus? YES NO
If **NO**, please go to **section 3**
If **YES**, please answer the following questions.
2. Is the diabetes managed by:-
- (a) Insulin? YES NO
If **YES**, please give date started on insulin
- (b) If treated with insulin, are there at least 3 months of blood glucose readings stored on a memory meter(s)? YES NO
If **NO**, please give details in **section 6**
- (c) Other injectable treatments? YES NO
- (d) A Sulphonylurea or a Glinide? YES NO
- (e) Oral hypoglycaemic agents and diet? YES NO
If **YES** to any of a-e, please fill in current medication in **section 8**
- (f) Diet only? YES NO
3. (a) Does the applicant test blood glucose at least twice every day? YES NO
- (b) Does the applicant test at times relevant to driving? YES NO
- (c) Does the applicant keep fast acting carbohydrate within easy reach when driving? YES NO
- (d) Does the applicant have a clear understanding of diabetes and the necessary precautions for safe driving? YES NO
4. Is there any evidence of impaired awareness of hypoglycaemia? YES NO
5. Is there a history of hypoglycaemia in the last 12 months requiring the assistance of another person? YES NO
6. Is there evidence of:-
- (a) Loss of visual field? YES NO
- (b) Severe peripheral neuropathy, sufficient to impair limb function for safe driving? YES NO
- If **YES** to any of 4-6 above, please give details in **section 6**
7. Has there been laser treatment or intra-vitreous treatment for retinopathy? YES NO
-
- If **YES**, please give date(s) of treatment.

Applicant's full name

Date of birth

3 Psychiatric illness

Is there a history of, or evidence of, **ANY** of the conditions listed at 1–7 below?

- Please enclose relevant hospital notes
- If applicant remains under specialist clinic(s), ensure details are filled in at section 7.

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Significant psychiatric disorder within the past 6 months | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Psychosis or hypomania/mania within the past 3 years, including psychotic depression | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Dementia or cognitive impairment | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Persistent alcohol misuse in the past 12 months | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Alcohol dependence in the past 3 years | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Persistent drug misuse in the past 12 months | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Drug dependence in the past 3 years | <input type="checkbox"/> | <input type="checkbox"/> |

If yes to **ANY** of questions 4-7, please state how long this has been controlled

Please give details of past consumption or name of drug(s) and frequency

4 Cardiac

4A Coronary artery disease

- | | YES | NO |
|---|--------------------------|--------------------------|
| Is there a history of, or evidence of, coronary artery disease? | <input type="checkbox"/> | <input type="checkbox"/> |

If **NO**, go to **section 4B**

If **YES**, please answer all questions below and give details at **section 6** of the form and enclose relevant hospital notes.

- Has the applicant suffered from Angina? YES NO
If **YES**, please give the date of the last known attack
- Acute coronary syndromes including Myocardial infarction? YES NO
If **YES**, please give date
- Coronary angioplasty (P.C.I.) YES NO
If **YES**, please give date of most recent intervention
- Coronary artery by-pass graft surgery? YES NO
If **YES**, please give date

Applicant's full name

Date of birth

4B Cardiac arrhythmia

- | | YES | NO |
|--|--------------------------|--------------------------|
| Is there a history of, or evidence of, cardiac arrhythmia? | <input type="checkbox"/> | <input type="checkbox"/> |

If **NO**, go to **section 4C**

If **YES**, please answer all questions below and give details in **section 6**

- Has there been a **significant** disturbance of cardiac rhythm? i.e. Sinoatrial disease, significant atrio-ventricular conduction defect, atrial flutter/fibrillation, narrow or broad complex tachycardia in the last 5 years YES NO
- Has the arrhythmia been controlled satisfactorily for at least 3 months? YES NO
- Has an ICD or biventricular pacemaker (CRST-D type) been implanted? YES NO
- Has a pacemaker been implanted? YES NO

If **YES**:-

- Please supply date of implantation
- Is the applicant free of symptoms that caused the device to be fitted? YES NO
- Does the applicant attend a pacemaker clinic regularly? YES NO

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

4C

- | | YES | NO |
|---|--------------------------|--------------------------|
| Is there a history of, or evidence of, ANY of the following: | <input type="checkbox"/> | <input type="checkbox"/> |

If **NO**, go to **section 4D**.

If **YES**, please answer all questions below and give details in **section 6**

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Peripheral arterial disease (excluding Buerger's disease) | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Does the applicant have claudication?
If YES , how long in minutes can the applicant walk at a brisk pace before being symptom-limited?
Please give details <input type="text"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Aortic aneurysm
If YES :
(a) Site of Aneurysm: Thoracic <input type="checkbox"/> Abdominal <input type="checkbox"/>
(b) Has it been repaired successfully? <input type="checkbox"/> YES <input type="checkbox"/> NO
(c) Is the transverse diameter currently > 5.5 cm? <input type="checkbox"/> YES <input type="checkbox"/> NO
If NO , please provide latest measurement and date obtained <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Dissection of the aorta repaired successfully
If YES , please provide copies of all reports to include those dealing with any surgical treatment. | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Is there a history of Marfan's disease?
If YES , provide relevant hospital notes | <input type="checkbox"/> | <input type="checkbox"/> |

4D Valvular/congenital heart disease

YES NO

Is there a history of, or evidence of, valvular/congenital heart disease?

If **NO**, go to **section 4E**

If **YES**, please answer all questions below and give details in **section 6** 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)

4E Cardiac other

Does the applicant have a history of **ANY** of the following conditions:

If **NO**, go to **section 4F**

If **YES**, please answer **ALL** questions and give details in **section 6**

- (a) a history of, or evidence of, heart failure?
- (b) established cardiomyopathy?
- (c) has a Left Ventricular Assist Device (LVAD) been implanted?
- (d) a heart or heart/lung transplant?
- (e) untreated atrial myxoma

4F Cardiac investigations

This section must be filled in 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?
 - (c) right bundle branch block?

If yes to a, b or c please provide a copy of the relevant ECG report or comment at **section 6**

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

If **YES**, please give date and
give details in **section 6**

Please provide relevant reports if available

3. Has an echocardiogram been undertaken (or planned)?

(a) If **YES**, please give date
and give details in **section 6**

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

Please provide relevant reports if available

4. Has a coronary angiogram been undertaken (or planned)?

If **YES**, please give date
and give details in **section 6**

Please provide relevant reports if available

5. Has a 24 hour ECG tape been undertaken (or planned)?

If **YES**, please give date
and give details in **section 6**

Please provide relevant reports if available

6. Has a myocardial perfusion scan or stress echo study been undertaken (or planned)?

If **YES**, please give date
and give details in **section 6**

Please provide relevant reports if available

4G Blood pressure

1. Please record today's blood pressure reading

YES NO

2. Is the applicant on anti-hypertensive treatment?

If **YES** provide three previous readings with dates if available

Applicant's full name

Date of birth

5 General

Please answer **ALL** questions. If 'YES' to any give full details in **section 6**.

YES NO

1. Is there **currently** any functional impairment that is likely to affect control of the vehicle?
2. Is there a history of bronchogenic carcinoma or other malignant tumour with a significant liability to metastasise cerebrally?
3. Is there any illness that may cause significant fatigue or cachexia that affects safe driving?
4. Is the applicant profoundly deaf?
If **YES**, is the applicant able to communicate in the event of an emergency by speech or by using a device, e.g. a textphone?
5. Does the applicant have a history of liver disease of any origin?
If **YES**, please give details in **section 6**
6. Is there a history of renal failure?
If **YES**, please give details in **section 6**
7. (a) Is there a history of, or evidence of, obstructive sleep apnoea syndrome?
(b) Is there any other **medical condition** causing excessive daytime sleepiness?
If **YES**, please give diagnosis

If **YES**, to 7a or b please give
(i) Date of diagnosis
(ii) Is it controlled successfully?
(iii) If **YES**, please state treatment

(iv) Please state period of control

(v) Date last seen by consultant
8. Does the applicant have severe symptomatic respiratory disease causing chronic hypoxia?
9. Does any medication currently taken cause the applicant side effects that could affect safe driving?
If **YES**, please provide details of medication and symptoms in **section 6**
10. Does the applicant have an ophthalmic condition?
If **YES**, please provide details in **section 6**
11. Does the applicant have any other medical condition that could affect safe driving?
If **YES**, please provide details in **section 6**

6 Further details

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

Applicant's full name

Date of birth

7 Consultants' details

Details of type of specialist(s)/consultants, including address.

Consultant in
Name
Address

Date of last appointment

D	D	M	M	Y	Y
---	---	---	---	---	---

Consultant in
Name
Address

Date of last appointment

D	D	M	M	Y	Y
---	---	---	---	---	---

Consultant in
Name
Address

Date of last appointment

D	D	M	M	Y	Y
---	---	---	---	---	---

8 Medication

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

Medication	Dosage
Reason for taking:	

Medication	Dosage
Reason for taking:	

Medication	Dosage
Reason for taking:	

Medication	Dosage
Reason for taking:	

Medication	Dosage
Reason for taking:	

9 Additional information

Patient's weight (kg)

Height (cms)

Details of smoking habits, if any

Number of alcohol units taken each week

Examining doctor's details

To be filled in by doctor carrying out the examination

Please ensure all sections of the form have been completed. Failure to do so will result in the form being rejected.

10 Doctor's details (please print name and address in capital letters)

Name

Address

Telephone

Email address

Fax number

Surgery stamp

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GMC registration number

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Signature of medical practitioner

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Date of examination

D	D	M	M	Y	Y
---	---	---	---	---	---

Applicant's full name

Date of birth

D	D	M	M	Y	Y
---	---	---	---	---	---

Applicant's details

To be filled-in in the presence of the doctor 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

11 Your details

Your full name
Your address
Email address

Date of birth	DDMMYY
Home phone number	
Work/daytime number	
Date when first licensed to drive a lorry	DDMMYY
and/or bus	DDMMYY

About your doctor/group practice

Doctor/group name
Address
Phone
Email address
Fax number

12 Applicant's consent and declaration

Consent and declaration

This section **MUST** be filled in and must **NOT** be altered in any way.

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

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 doctor(s) of the outcome of my case

Release reports to my doctor(s)

Applicant's full name

Date of birth DDMMYY