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.
The INF4D leaflet is available to download at **www.gov.uk/drivingmedicalapplications**
Please check the applicant's identity before you proceed.

D4

Driver and Vehicle Licensing Agency

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.

You MUST answer ALL the following questions

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.

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) D D M M Y Y

Name (print)

Signature

Date of signature D D M M Y Y

Please provide your GOC, HPC or GMC number

Doctor/optometrist/optician's stamp

Applicant's full name **Date of birth** D D M M Y Y

Please do not detach this page

CUSTOMER SERVICE EXCELLENCE CSE

An executive agency of the Department for **Transport**

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 – this leaflet is available to download at **www.gov.uk/drivingmedicalapplications**

Driver and Vehicle Licensing Agency

D4

1 Nervous system

Please tick ✓ the appropriate box(es) — YES NO

1. Has the applicant had any form of seizure? ☐ ☐
   If **NO,** please go to **question 2**
   If **YES**, please answer questions a-f
   (a) Has the applicant had more than one attack? ☐ ☐
   (b) Please give date of first and last attack
   First attack D D M M Y Y
   Last attack D D M M Y Y
   (c) Is the applicant currently on anti-epileptic medication? ☐ ☐
   If **YES,** please fill in current medication in **section 8**
   (d) If no longer treated, please give date when treatment ended D D M M Y Y
   (e) Has the applicant had a brain scan? ☐ ☐
   If **YES,** please give details in section 6
   (f) Has the applicant had an EEG? ☐ ☐
   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? ☐ ☐
   If **YES,** please give date(s) and details in **section 6**

3. Does the applicant suffer from narcolepsy or cataplexy ☐ ☐
   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? ☐ ☐
   If **NO,** go to **question 2**
   If **YES**, please give full details at **section 6** and supply relevant reports
   (a) Stroke or TIA ☐ ☐
   If **YES**, please give date D D M M Y Y
   Has there been a **full** recovery? ☐ ☐
   Has a carotid ultra sound been undertaken? ☐ ☐
   (b) Sudden and disabling dizziness/vertigo within the last year with a liability to recur ☐ ☐
   (c) Subarachnoid haemorrhage ☐ ☐
   (d) Serious traumatic brain injury within the last 10 years ☐ ☐
   (e) Any form of brain tumour ☐ ☐
   (f) Other brain surgery or abnormality ☐ ☐
   (g) Chronic neurological disorders ☐ ☐
   (h) Parkinson's disease ☐ ☐

2 Diabetes mellitus

YES NO

1. Does the applicant have diabetes mellitus? ☐ ☐
   If **NO,** please go to **section 3**
   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) If treated with insulin, are there at least 3 months of blood glucose readings stored on a memory meter(s)? ☐ ☐
   If **NO**, please give details in **section 6**
   (c) Other injectable treatments? ☐ ☐
   (d) A Sulphonylurea or a Glinide? ☐ ☐
   (e) Oral hypoglycaemic agents and diet? ☐ ☐
   If **YES** to any of a-e, please fill in current medication in **section 8**
   (f) Diet only? ☐ ☐

3. (a) Does the applicant test blood glucose at least twice every day? ☐ ☐
   (b) Does the applicant test at times relevant to driving? ☐ ☐
   (c) Does the applicant keep fast acting carbohydrate within easy reach when driving? ☐ ☐
   (d) Does the applicant have a clear understanding of diabetes and the necessary precautions for safe driving? ☐ ☐

4. Is there any evidence of impaired awareness of hypoglycaemia? ☐ ☐

5. Is there a history of hypoglycaemia in the last 12 months requiring the assistance of another person? ☐ ☐

6. Is there evidence of:-
   (a) Loss of visual field? ☐ ☐
   (b) Severe peripheral neuropathy, sufficient to impair limb function for safe driving? ☐ ☐
   If **YES** to any of 4-6 above, please give details in **section 6**

7. Has there been laser treatment or intra-vitreal treatment for retinopathy? ☐ ☐
   If **YES**, please give date(s) of treatment.

Applicant's full name _____ **Date of birth** D D M M Y Y

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	☐	☐
2. Psychosis or hypomania/mania within the past 3 years, including psychotic depression	☐	☐
3. Dementia or cognitive impairment	☐	☐
4. Persistent alcohol misuse in the past 12 months	☐	☐
5. Alcohol dependence in the past 3 years	☐	☐
6. Persistent drug misuse in the past 12 months	☐	☐
7. Drug dependence in the past 3 years	☐	☐

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?	☐	☐

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.

1. Has the applicant suffered from Angina?	☐	☐
If **YES**, please give the date of the last known attack (D D M M Y Y)		
2. Acute coronary syndromes including Myocardial infarction?	☐	☐
If **YES**, please give date (D D M M Y Y)		
3. Coronary angioplasty (P.C.1)?	☐	☐
If **YES**, please give date of most recent intervention (D D M M Y Y)		
4. Coronary artery by-pass graft surgery?	☐	☐
If **YES**, please give date (D D M M Y Y)		

4B Cardiac arrhythmia

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

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

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

1. 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	☐	☐
2. Has the arrhythmia been controlled satisfactorily for at least 3 months?	☐	☐
3. Has an ICD or biventricular pacemaker (CRST-D type) been implanted?	☐	☐
4. Has a pacemaker been implanted?	☐	☐
If **YES:-**		
(a) Please supply date of implantation (D D M M Y Y)		
(b) Is the applicant free of symptoms that caused the device to be fitted?	☐	☐
(c) Does the applicant attend a pacemaker clinic regularly?	☐	☐

4C Peripheral arterial disease (excluding Buerger's disease) aortic aneurysm/dissection

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

If **NO**, go to **section 4D**.
If **YES**, please answer all questions below and give details in **section 6**

1. Peripheral arterial disease (excluding Buerger's disease)	☐	☐
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		
3. Aortic aneurysm	☐	☐
If **YES:**		
(a) Site of Aneurysm: Thoracic ☐ Abdominal ☐		
(b) Has it been repaired successfully?	☐	☐
(c) Is the transverse diameter **currently** > 5.5 cm?	☐	☐
If **NO**, please provide latest measurement and date obtained		
(D D M M Y Y)		
4. Dissection of the aorta repaired successfully	☐	☐
If **YES**, please provide copies of all reports to include those dealing with any surgical treatment.		
5. Is there a history of Marfan's disease?	☐	☐
If **YES**, provide relevant hospital notes		

Applicant's full name **Date of birth** (D D M M Y Y)

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

YES NO

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** D D M M Y Y

   Please provide relevant reports if available

YES NO

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

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

   (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** D D M M Y Y

   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** D D M M Y Y

   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** D D M M Y Y

   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

   ☐ D D M M Y Y

   ☐ D D M M Y Y

   ☐ D D M M Y Y

Applicant's full name ☐ **Date of birth** D D M M Y Y

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 D D M M Y Y

(ii) Is it controlled successfully?	☐	☐

(iii) If **YES**, please state treatment

(iv) Please state period of control

(v) Date last seen by consultant D D M M Y Y

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 D D M M Y Y

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

GMC registration number

Signature of medical practitioner

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 D D M M Y Y

Home phone number

Work/daytime number

Date when first licensed to drive a lorry D D M M Y Y

and/or bus D D M M Y Y

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** D D M M Y Y