**Medical** **examination** **report** **for** **a** **Group** **2** **(bus** **or** **lorry)** **licence**

For advice on how to fill in this form, read the leaflet INF4D available at **www.gov.uk/reapply-driving-licence-medical-condition**

Please use black ink when you fill in this report.

**D4**

**Applicants:** **you** **must** **fill** **in** **all** **grey** **sections** **of** **this** **report.** **This** **includes** **the** **section** **below,** **your** **full** **name** **and** **date** **of** **birth** **at** **the** **end** **of** **each** **page** **and** **the** **declaration** **on** **page** **8.**

**Important:** **This** **report** **is** **only** **valid** **for** **4** **months** **from** **date** **of** **examination.**

Name

**Medical** **professionals** **must** **fill** **in** **all** **green** **sections** **on** **this** **report.**

**Important** **information** **for** **doctors** **carrying** **out** **examinations.**

Before you fill in this report, you must check the applicant’s identity and decide if you are able to fill in the Vision assessment on page 2. If you are unable to do this, you must inform the applicant that they will need to ask an optician or optometrist to fill in the Vision assessment.

Date of birth

Address

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

**Examining** **medical** **professional** Y Name

Has a company employed you or booked you to carry out this examination?

Yes ■No ■

Postcode

Contact number

If Yes, you **must** give the company’s details below.

If ‘No’, you must give your practice address details below. (Refer to section C of INF4D.)

Company or practice address

Email address

Date first licensed to drive a bus or lorry Y

If you do not want to receive survey invitations by email from DVLA, please tick box ■

Your doctor’s details (only fill in **if** **different** from examining doctor’s details)

GP’s name

Postcode

Company or practice contact number

Company or practice email address

GMC registration number Practice address

**I** **can** **confirm** **that** **I** **have** **checked** **the** **applicant’s** **documents** **to** **prove** **their** **identity.**

Signature of examining doctor

Applicant’s weight (kg) Applicant’s height (cm)

Postcode

Contact number Number of alcohol units consumed each week

Units per week

Email address Does the applicant smoke?

Do you have access to the applicant’s full medical record?

Yes ■No ■

Yes ■No ■

Important: Signatures must be provided at the end of this report

1 7/21

**Medical** **examination** **report**

**Vision** **assessment** **D4** **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. Snellen readings with a plus (+) or minus (-) are not acceptable. If 6/7.5, 6/60 standard is not met, the applicant may need

**5.** Does the applicant report symptoms of any of the following that impairs their ability to drive?

Please indicate below and give full details in Q7 below.

(a) Intolerance to glare (causing incapacity rather than discomfort) and/or

(b) Impaired contrast sensitivity and/or

(c) Impaired twilight vision

Yes No ■ ■

**■**

**■**

further assessment by an optician.

R L Yes No

(b) Are corrective lenses worn for driving? ■ ■ **If** **No,** **go** **to** **Q3**.

**6.** Does the applicant have any other ophthalmic condition affecting their visual acuity or visual field?

If Yes, please give full details in Q7 below.

Yes No ■ ■

If Yes, please provide the visual acuities using the correction worn for driving. Snellen readings with a plus (+) or minus (-) are not acceptable.

If 6/7.5, 6/60 standard is not met, the applicant may need further assessment by an optician.

**7.** Details or additional information

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?

(e) If correction is worn for driving, is it well tolerated?

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)?

If Yes, please give full details below.

Yes No ■ ■ Yes No ■ ■

Yes No ■ ■

Name of examining doctor or optician undertaking vision assessment

**I** **confirm** **that** **this** **report** **was** **filled** **in** **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 |

If formal visual field testing is considered necessary, Please provide your GOC or GMC number DVLA will commission this at a later date.

Doctor, optometrist or optician’s stamp **4.** Is there diplopia? Yes No

(a) Is it controlled? ■ ■ Please indicate below and give full details in Q7.

Patch or Glasses Other

glasses with with/without (if other please frosted glass prism provide details)

**Applicant’s** **full** **name** **Date** **of** **birth**

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

Y

**Please** **do** **not** **detach** **this** **page**

2

**Medical** **examination** **report**

**Medical** **assessment** **D4** **Must** **be** **filled** **in** **by** **a** **doctor**

**1** **Neurological** **disorders** **2** **Diabetes** **mellitus**

3

**3** **Cardiac** **c** **Peripheral** **arterial** **disease**

**a** **Coronary** **artery** **disease**

Is there a history or evidence of coronary artery disease?

**If** **No,** **go** **to** **section** **3b,** **Cardiac** **arrhythmia** If Yes, please answer all questions below

and enclose relevant hospital notes.

Yes No ■ ■

**1.** Has the applicant ever had an episode Yes of angina?

If Yes, please give the date of the last known attack.

**2.** Acute coronary syndrome including Yes myocardial infarction?

If Yes, please give date.

**3.** Coronary angioplasty (PCI)? Yes

If Yes, please give date of most recent intervention.

**4.** Coronary artery bypass graft surgery? Yes

If Yes, please give date.

No ■

No ■

No ■

No ■

**5.** If Yes to any of the above, are there any Yes No 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.

**b** **Cardiac** **arrhythmia**

Is there a history or evidence of Yes cardiac arrhythmia?

**If** **No,** **go** **to** **section** **3c,** **Peripheral** **arterial** **disease**

If Yes, please answer all questions below and enclose relevant hospital notes.

No ■

**d** **Valvular/congenital** **heart** **disease**

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

**If** **No,** **go** **to** **section** **3e,** **Cardiac** **other**

Yes No ■ ■

**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?

**2.** Has the arrhythmia been controlled satisfactorily for at least 3 months?

**3.** Has an ICD (Implanted Cardiac Defibrillator) or biventricular pacemaker with defibrillator/

cardiac resynchronisation therapy defibrillator (CRT-D type) been implanted?

Yes No ■ ■

Yes No ■ ■

Yes No ■ ■

If Yes, answer all questions below and provide relevant hospital notes.

**1.** Is there a history of congenital heart disease?

**2.** Is there a history of heart valve disease?

**3.** Is there a history of aortic stenosis?

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

Yes No ■ **■**

Yes No ■ **■**

Yes No ■ **■**

**4.** Has a pacemaker or a biventricular pacemaker/ cardiac resynchronisation therapy pacemaker Yes (CRT-P type) been implanted?

If Yes:

(a) Please give date of implantation.

No ■

**4.** Is there history of embolic stroke?

**5.** Does the applicant currently have significant symptoms?

Yes No ■ **■**

Yes No ■ **■**

(b) Is the applicant free of the symptoms that caused the device to be fitted?

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

■ ■ ■ ■

**6.** Has there been any progression (either clinically or on scans etc) since the last licence application?

Yes No ■ **■**

**Applicant’s** **full** **name** **Date** **of** **birth** D D M M Y Y 4

**e** **Cardiac** **other**

**Note:** **If** **Yes** **to** **questions** **2** **to** **6,** **please** **give** **dates** **in** **the** **boxes** **provided,** **give** **details** **in** **section** **9,** **page** **7** **and** **provide** **relevant** **reports.**

Is there a history or evidence of heart failure? Yes **If** **No,** **go** **to** **section** **3f,** **Cardiac** **channelopathies** ■

If Yes, please answer all questions and enclose relevant hospital notes.

**1.** Please provide the NYHA class, if known.

**2.** Established cardiomyopathy? Yes If Yes, please give details in section 9, page 7.

**3.** Has a left ventricular assist device (LVAD) or Yes other cardiac assist device been implanted?

No ■

No ■ No ■

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

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

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

**4.** Has a coronary angiogram been undertaken (or planned)? D D M M Y Y

Yes No ■ ■

Yes No ■ ■

■ ■

Yes No ■ ■

**4.** A heart or heart/lung transplant?

**5.** Untreated atrial myxoma?

**f** **Cardiac** **channelopathies**

Is there a history or evidence of the following conditions?

**If** **No,** **go** **to** **section** **3g,** **Blood** **pressure**

Yes No ■ ■ Yes No ■ ■

Yes No ■ ■

**5.** Has a 24 hour ECG tape been undertaken (or planned)? D D M M Y Y

**6.** Has a loop recorder been implanted

(or planned)? D D M M Y Y

**7.** Has a myocardial perfusion scan, stress echo study or cardiac MRI been undertaken (or planned)? D D M M Y Y

Yes No

Yes No ■ ■

Yes No ■ ■

**1.** Brugada syndrome? Yes No **4** **Psychiatric** **illness**

**2.** Long QT syndrome?

If Yes to either, please give details in section 9, page 7 and enclose relevant hospital notes.

**g** **Blood** **pressure**

**All** **questions** **must** **be** **answered.**

Yes No ■ ■

Is there a history or evidence of psychiatric Yes illness within the last 3 years?

**If** **No,** **go** **to** **section** **5,** **Substance** **misuse** If Yes, please answer all questions below.

**1.** Significant psychiatric disorder within the Yes past 6 months? If Yes, please confirm condition. ■

No ■

No ■

If resting blood pressure is 180 mm/Hg systolic or more and/or 100mm/Hg diastolic or more, please take a further 2 readings at least 5 minutes apart and record the best of the 3 readings in the box provided.

**1.** Please record today’s best resting blood pressure reading.

**2.** Is the applicant on anti-hypertensive treatment? Yes No If Yes, please 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

**2.** Psychosis or hypomania/mania within the Yes past 12 months, including psychotic depression?

**3.** (a) Dementia or cognitive impairment? Yes (b) Are there concerns which have resulted

in ongoing investigations for such possible diagnoses?

**5** **Substance** **misuse**

Is there a history of drug/alcohol misuse Yes or dependence?

**If** **No,** **go** **to** **section** **6,** **Sleep** **disorders** If Yes, please answer all questions below.

No

No ■

■

No ■

**3.** Is there a history of malignant hypertension? Yes No If Yes, please give details in section 9,

page 7 (including date of diagnosis and any treatment etc).

**h** **Cardiac** **investigations**

**1.** Is there a history of alcohol dependence in the past 6 years?

(a) Is it controlled?

(b) Has the applicant undergone an alcohol detoxification programme?

Yes No

**■** ■ ■ ■ ■ ■

Have any cardiac investigations been Yes No undertaken or planned?

**If** **No,** **go** **to** **section** **4,** **Psychiatric** **illness** If Yes, please answer questions 1 to 7.

**1.** Has a resting ECG been undertaken? Yes No 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 in section 9, page 7.

If Yes, give date started: D D M M Y Y **2.** Persistent alcohol misuse in the past 3 years? Yes No

(a) Is it controlled? ■ ■ **3.** Use of illegal drugs or other substances,ormisuse Yes No

of prescription medication in the last 6 years? (a) If Yes, the type of substance misused?

(b) Is it controlled? ■ **■** (c) Has the applicant undertaken an opiate

treatment programme?

If Yes, give date started

**Applicant’s** **full** **name** **Date** **of** **birth** D D M M Y Y 5

**6** **Sleep** **disorders**

**1.** Is there a history or evidence of Obstructive Yes No Sleep Apnoea Syndrome or any other medical condition causing excessive sleepiness?

**If** **No,** **go** **to** **section** **7,** **Other** **medical** **conditions**.

If Yes, please give diagnosis and answer all questions below.

**6.** Does the applicant have a history Yes of liver disease of any origin?

If Yes, is this the result of alcohol misuse?

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

**7.** Is there a history of renal failure? Yes If Yes, please give details in section 9, ■

page 7.

No ■

■

No ■

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.

**8.** Does the applicant have severe symptomatic Yes respiratory disease causing chronic hypoxia?

**9.** Does any medication currently taken cause Yes the applicant side effects that could affect

safe driving?

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

**10.** Does the applicant have any other medical Yes condition that could affect safe driving? ■

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

No ■

No ■

No ■

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

(i) Date of diagnosis: Yes (ii) Is it controlled successfully?

(iii) If Yes, please state treatment.

Yes

(iv) Is applicant compliant with treatment? ■ (v) Please state period of control:

No **■**

No **■**

**8** **Medication**

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Medication | Dosage | | | | | | |
|  |  | | | | | | |
| Reason for taking: | | | | | | | |
| Approximate date started (if known): | | D | D | M | M | Y | Y |

years months

(vi) Date of last review.

**7** **Other** **medical** **conditions**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Medication | Dosage | | | | | | |
|  |  | | | | | | |
| Reason for taking: | | | | | | | |
| Approximate date started (if known): | | D | D | M | M | Y | Y |

Yes No **1.** Is there a history or evidence of narcolepsy? ■ **■**

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

**3.** Is there a history of bronchogenic carcinoma Yes or other malignant tumour with a significant

liability to metastasise cerebrally?

**4.** Is there any illness that may cause significant Yes fatigue or cachexia that affects safe driving?

No ■

No ■

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Medication | Dosage | | | | | | |
|  |  | | | | | | |
| Reason for taking: | | | | | | | |
| Approximate date started (if known): | | D | D | M | M | Y | Y |

**5.** 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?

Yes No ■ ■

Yes No ■ ■

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Medication | Dosage | | | | | | |
|  |  | | | | | | |
| Reason for taking: | | | | | | | |
| Approximate date started (if known): | | D | D | M | M | Y | Y |

6

**9** **Further** **details** **10** **Consultants’** **details**

Please send us copies of relevant hospital notes. Do not send any notes not related to fitness to drive. Use the space below to provide any additional information.

Please provide details of type of specialists or consultants, including address.

|  |
| --- |
| Consultant in |
| Reason for attendance |
| Name |
| Address |
|  |
|  |

Date of last appointment:

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

|  |
| --- |
| Consultant in |
| Reason for attendance |
| Name |
| Address |
|  |
|  |

Date of last appointment:

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

If more consultants seen give details on a separate sheet.

**11** **Examining** **doctor’s** **signature** **and** **stamp**

To be filled in by the doctor carrying out the examination.

Please make sure all sections of the form have been filled in. The form will be returned to you if you do not do this.

I confirm that this report was filled in by me at examination and I have taken the applicant’s history into account. I also confirm that I am currently GMC registered and licensed to practise in the UK or I am a doctor who is medically registered within the EU, if the report was filled in outside the UK.

**Signature** **of** **examining** **doctor**

**Date** **of** **signature**

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

**Doctor’s** **stamp**

7

**The** **applicant** **must** **fill** **in** **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

**Name**

**Signature**

**Date**

**I** **authorise** **the** **Secretary** **of** **State** **to:**

**Yes** **inform** **my** **doctors** **about**

**the** **outcome** **of** **my** **case**

**release** **reports** **to** **my** **doctor(s)**

**Contact** **me** **about** **my** **application** **by:**

**Yes**

**email** ■ **SMS** **(text** **message)** ■

**(Please** **note:** **DVLA** **will** **continue**

**to** **contact** **you** **by** **post** **if** **you** **do** **not**

**No**

**■** **■**

**No**

**■** **■**

State’s Honorary Medical Advisory Panels. **wish** **to** **be** **contacted** **by** **email** **or** **text.)** Panel members must adhere strictly to the

principle of confidentiality. **Checklist** **Yes**

**Declaration**

I authorise my doctor and specialist to release

• Have you signed and dated the declaration?

■

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.

• Have you checked that the optician or doctor has filled in all parts of the report and

all relevant hospital notes have been enclosed?

**Important**

**Yes**

■

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.

**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.**

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