



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

DLM1

**Do not complete the vision assessment
until you have read the following**

Important information for doctors

Please read and follow the information below before deciding if you are able to **fully** and **accurately** fill in the vision assessment. **If you are unable to do this, you must tell the applicant that they will need to ask an optician or optometrist to fill it in.**

We will make a licensing decision based on the information you provide.

What you need to assess

If glasses (not contact lenses) are worn for driving, you MUST be able to establish the dioptre measurement of the correction used. If the correction is greater than +8 dioptres in any meridian of either lens, we may not be able to issue a Group 2 licence.

Applicants for Group 2 (lorry or bus) entitlements must have, as measured by the 6 metre Snellen chart:

- a visual acuity of at least **6/7.5** (decimal Snellen equivalent 0.8) in the better eye
- a visual acuity of at least **6/60** (decimal Snellen equivalent 0.1) in the other eye
- this may be achieved with or without glasses or contact lenses
- we cannot accept a Snellen reading shown with a plus (+) or minus (-) e.g. 6/6-2 or 6/9+3
- 3 metre readings must be converted to the 6 metre equivalent

Note: Drivers first licensed to drive Group 2 vehicles before 31 December 1996 who cannot meet the above standards may still be considered by DVA on an individual basis. Please see <https://www.nidirect.gov.uk/articles/lorry-and-bus-licence-medical-questionnaires> for further information.

Before you fill in this report please:

- check the applicant's identity
- read the information at <https://www.nidirect.gov.uk/articles/lorry-and-bus-licence-medical-questionnaires>

The applicant is responsible for any fee payable for completion of the assessment.
DVA will not be liable for any costs involved.

Please note that if you complete the vision assessment as well as the medical assessment, you must sign and date **both** parts of the form.



Medical examination report

Vision assessment

DLM1

To be filled in by a doctor or optician/optometrist.

You **MUST** read the guidance notes on page 1 before completing this report.

If correction is needed to meet the eyesight standard for driving, **ALL** questions must be answered. If correction is **NOT** needed, questions 5 and 6 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. Is the visual acuity at least 6/7.5 in the better eye and at least 6/60 in the other eye (corrective lenses may be worn to meet this standard) **YES NO** ☐ ☐

3. Were corrective lenses worn to meet this standard? **N/A YES NO** ☐ ☐ ☐

If **Yes**, glasses ☐ contact lenses ☐ both together ☐

4. 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)

L	R	L	R
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5. If **glasses** (not contact lenses) are worn for driving, is the corrective power greater than plus (+)8 dioptres in any meridian of either lens? ☐ ☐

6. If correction is worn for driving, is it well tolerated?
If **No**, please give full details in the box provided ☐ ☐

If you answer yes to any of the following give details in the box provided.

7. 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, DVA will commission this at a later date

8. Is there diplopia? ☐ ☐
(a) Is it controlled? ☐ ☐
If **yes**, please give full details in the box provided

9. Does the applicant on questioning, report symptoms of intolerance to glare and/or impaired contrast sensitivity and/or impaired twilight vision? ☐ ☐

10. Does the applicant have any other ophthalmic condition? ☐ ☐

Details/additional information

Date of eyesight examination if different to date of signature

Name of examining doctor/optician (print)

Signature of examining doctor/optician

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 INSV1 leaflet (Information and useful notes) to help you complete this form

DLM1

1 Nervous system

Questions 1-4 below **MUST** be answered.

Please tick ✓ the appropriate box(es)

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Has the applicant had any form of seizure? | ☐ | ☐ |
| (a) Has the applicant had more than one attack? | ☐ | ☐ |
| (b) Please give date of first and last attack | | |
| First attack | <input type="text"/> | <input type="text"/> |
| Last attack | <input type="text"/> | <input type="text"/> |
| (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 | <input type="text"/> | <input type="text"/> |
| (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? | ☐ | ☐ |
| 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 section 2 | | |
| If YES , please give full details in section 6 and supply relevant reports | | |
| (a) Stroke or TIA | ☐ | ☐ |
| If YES , please give date | <input type="text"/> | <input type="text"/> |
| 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 , 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 | <input type="text"/> | <input type="text"/> |
| (b) if treated with insulin, are there at least 4 continuous weeks of 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 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 keep a finger prick glucose monitor with them when driving? | ☐ | ☐ |
| (e) 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-vitreous treatment for retinopathy? | ☐ | ☐ |
| If YES , please give date(s) of treatment. | | |

Applicant's full name

Date of birth

3 Psychiatric illness

All questions must be answered

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

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

- | | 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

- Is there a history of, or evidence of, coronary artery disease?
- | YES | NO |
|--------------------------|--------------------------|
| ☐ | ☐ |

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 date of most recent intervention
- Acute coronary syndrome 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

4b Cardiac arrhythmia

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

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 (CRT-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

Is there a history of, or evidence of, **ANY** of the following:

- If **NO**, go to **section 4d**.
- | YES | NO |
|--------------------------|--------------------------|
| ☐ | ☐ |

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

- Peripheral arterial disease (excluding Buerger's disease) ☐ YES ☐ NO
- Does the applicant have claudication? ☐ YES ☐ NO
If **YES**, how long in minutes can the applicant walk at a brisk pace before being symptom-limited?
Please give details
- Aortic aneurysm ☐ YES ☐ NO
If **YES**:
 - Site of Aneurysm: Thoracic ☐ Abdominal ☐
 - Has it been repaired successfully? ☐ YES ☐ NO
 - Is the transverse diameter **currently 5.5cm or less**? ☐ YES ☐ NO
If **NO**, please provide latest measurement and date obtained
- Dissection of the aorta repaired successfully ☐ YES ☐ NO
If **YES**, please provide copies of all reports to include those dealing with any surgical treatment.
- Is there a history of Marfan's disease? ☐ YES ☐ NO
If **YES**, provide relevant hospital notes

Applicant's full name

Date of birth

4d Valvular/congenital heart disease

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

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 a history of aortic stenosis? ☐ ☐
If **YES**, please provide relevant reports
4. Is there any history of embolism? (not pulmonary embolism) ☐ ☐
5. Does the applicant currently have significant symptoms? ☐ ☐
6. 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: YES NO ☐ ☐

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

All questions must be answered 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)? YES NO ☐ ☐

(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

2. Is the applicant on anti-hypertensive treatment? YES NO ☐ ☐

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

Applicant's full name

Date of birth

5 General

All questions must be answered

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? ☐ 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 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**, please give details in **section 6**
6. Is there a history of renal failure? ☐ YES ☐ NO
If **YES**, please give details in **section 6**
7. Is there a history of, or evidence of, obstructive sleep apnoea syndrome or any other medical condition causing excessive day time sleepiness? ☐ YES ☐ NO
If **YES**, please give diagnosis

Please give
(i) Date of diagnosis
(ii) Is it controlled successfully? ☐ YES ☐ NO
(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? ☐ YES ☐ NO
9. Does any medication currently taken cause the applicant side effects that could affect safe driving? ☐ YES ☐ NO
If **YES**, please provide details of medication and symptoms in **section 6**
10. Does the applicant have an ophthalmic condition? ☐ YES ☐ NO
If **YES**, please provide details in **section 6**
11. Does the applicant have any other medical condition that could affect safe driving? ☐ YES ☐ NO
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

Consultant in
Name
Address

Date of last appointment

Consultant in
Name
Address

Date of last appointment

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:	

Applicant's full name

Date of birth

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

I confirm that this report was completed at examination and that I am currently GMC registered and licensed to practice in the UK or I am a doctor who is registered to practice medicine within the EU, if the report was completed outside of the UK.

I am/am not* the applicant's doctor (or partner in the group) with which he/she is currently registered and I have/have not* had access to their full medical records.

***delete as appropriate**

GMC registration number

Signature of medical practitioner

Date of examination

If you have filled in both the vision and medical assessments, both sections must be signed and dated.

Applicant's details

To be filled-in in the presence of the
doctor carrying out the examination

DLM1

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

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

In order to process your application for Group 2 entitlement, we require your consent for the release of medical reports from your doctors and/or specialists for consideration by the Department's medical advisors. On occasion, applicants may be required to undergo a medical examination or some form of practical assessment. In these circumstances, the person conducting the examination or assessment may need to be aware of your medical records. Only information relevant to the assessment of your fitness to drive will be released.

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 Department's medical adviser.

I authorise the Department to disclose such relevant medical information as may be necessary to the investigation of my fitness to drive, to doctors, paramedical staff and Mobility & Driving Assessment staff.

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

The information provided on this form may be made available to other Departments/Agencies for the purposes of preventing or detecting crime.

Your personal information will be managed in accordance with the Privacy Notice available at

www.infrastructure-ni.gov.uk/dfi-privacy or
by calling 0300 200 7861.

Applicant's full name

Date of birth