***Part 67 respiratory examination report***



*Medical in confidence*

The Designated Medical Examiner should complete (or submit this form to a Consultant Physician for completion) in all cases where asthma has occurred within the past 5 years.

1. **APPLICANTS DETAILS** (to be completed by the applicant)

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Surname |  | | | Client | No: (if | issued) | | | | Rank or Title |
|  |  |  |  | |  | Mr, Mrs, Miss, Ms |
| Given names | |  |  | |  | | Place and date of birth | | |  |
| ............ / .......... /.......... |
| Class(es) of licence applied for | | ATPL | PPL | | ATCO | | Other (specify) | | | |
|  | | SCPL  CPL | SPL | |  | |  |  | | |

1. **MEDICAL HISTORY**

# Initial Assessment Only

1. **Initial and Subsequent Assessments**

|  |  |  |
| --- | --- | --- |
| Features since last assessment, (or in previous 5 years) -- Have there been any specific and identifiable attacks of asthma in the last 5 years or since the last assessment?  YES/NO | | |
| If YES, please answer the following  (a) give frequency of episodes date of last episode | |  |
| (b) how long do episodes last? (range of duration) |  | |
| (c) has treatment at or in hospital been necessary? (please give details)  YES/NO |  | |
| (d) has there been any acute attacks requiring urgent medical advice?  YES/NO |  | |
| (e) state any periods off work due to asthma |  | |

1. **MEDICATION**

|  |  |  |  |
| --- | --- | --- | --- |
| List drugs currently being administrated: Give information on the largest daily dose and lengths of periods of treatment, where possible. | | | |
| (a) Regularly on a daily basis:  — by inhalation |  | | |
| — orally |  | | |
| — by injection |  | | |
| (b) Intermittently:  — by inhalation |  | | |
| — orally |  | | |
| — by injection |  | | |
| (c) Bronchodilator inhalers. If any are being used, what number of refills are required annually? | | |  |
| (d) Steroid therapy. Has any steroid therapy been needed during the last 5 years?  If YES, give dose, duration and date last taken. | |  | |
|  | | | |
| (e) Side effects. Are there any side effects to current medication? If YES, please give details. | |  | |

# MEDICAL EXAMINATION

Results of auscultation

1. **SPECIAL INVESTIGATIONS**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| (a) Report of chest X-ray performed within three months. (For initial assessment and subsequently at the discretion of the medical examiner) | | | | |  | |
| (b) Lung Function Test (to be undertaken within 1 month of submitting this report). | | | | | | |
| Date |  | | Initial Readings | 15 Minutes after Bronchodilator | | Age/Height Predicted Normal |
| Mandatory at initial assessment | | FEV1 |  |  | |  |
| FVC |  |  | |  |
| FEV1/FVC | % | % | | Normally 75% or more |
| or | | PEFR |  |  | |  |
| (c) details of previous lung function tests. | | | | |  | |
| (d) comments on Lung Function Tests | | | | |  | |

**OPINION**

Do you consider the applicant fit for Flight Crew /ATCO duties?

1. With normal licence validity YES/NO
2. With restricted licence validity YES/NO State suggested period months

|  |  |  |
| --- | --- | --- |
| Date: |  | Address |
| Signature of Consultant or DME | |  |
|  | |