STATE OF FLORIDA DEPARTMENT OF HIGHWAY SAFETY AND MOTOR VEHICLES

Diabetes/Hypoglycemia
Follow-Up Form

RE:_____

DL#:_____

DOB: _____

Dear Physician:

This individual was previously reviewed by our Department for an episode of hypoglycemia on _____. We are in the process of reassessing his/her ability to safely operate a motor vehicle and need your input on the following questions:

1. How long have you treated the patient? When did you last see the patient in your office?

2. Has the patient experienced any further episodes of hypoglycemia?
   Yes _____ No_____

   If the answer is yes, please provide the date(s) and severity of the reaction(s).

3. What is your assessment of the control of the patient's diabetes?

4. What advice has the patient been given to prevent recurrence of hypoglycemia while driving?

5. To the best of your knowledge, is the patient sufficiently well instructed and conscientiously applying these instructions to the point that it is highly unlikely that they would have an episode of hypoglycemia while operating a motor vehicle?

   Yes _____ No _____

   Comments:

   _____

   _____

   _____

   _____

Mail this Completed Form to:
Bureau of Motorist Compliance
Medical Review Program
Neil Kirkman Building, MS 86
Tallahassee, Florida 32399-0500
Telephone No.: (850) 617-3814
Fax No.: (850) 617-3944

Signature of Physician: _____

Print Physician's Name: _____

Medical License #: _____

Address: _____

Telephone Number: _____

Date: _____