STATE OF FLORIDA DEPARTMENT OF HIGHWAY SAFETYAND MOTOR VEHICLES

Loss of Consciousness
Follow-Up Form

RE.:_____

DL#:_____

DOB: _____

Dear Physician:

This individual was previously reviewed by our Department for a loss of consciousness 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 loss of consciousness? Yes_ No_____ If the answer is yes, please provide the date(s) and probable cause of the episode(s).

3. What treatment, if any, is the patient currently receiving? Please include a list of any medication.

4. From a medical standpoint, do you believe that it is safe for the patient to continue to operate 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: _____