

FLORIDA DEPARTMENT OF HIGHWAY SAFETY AND MOTOR VEHICLES
Medical/Re-Exam Referral Form

This form is completed by examiners/agents to document observations and/or admissions by the customer concerning issues that may affect the customer's ability to safely operate a motor vehicle.

Customer Information

Name of Customer _____ DOB _____ Sex _____
Address _____ Telephone Number _____
Driver License Number _____ State _____ Type _____

Source of Information

A. Driver License Application

Examiner Name _____ Office Telephone Number _____

B. Informant / Written Complaint

Name of Informant _____ Relationship to Customer _____
Address of Informant _____ Telephone Number _____

Observations / Admissions

A. Customer's Admissions

- | | | |
|--|--|---|
| <input type="checkbox"/> Progressive Neurological Disorder | <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Dizzy Spells | <input type="checkbox"/> Alcohol/drug addiction within past 2 years |

Treating Physician Name _____ Telephone Number _____

B. Examiner/Agent Observations

- | | |
|---|--|
| <input type="checkbox"/> Difficulty with Mobility | <input type="checkbox"/> Lack of Comprehension or Orientation |
| <input type="checkbox"/> Hearing or Visual | <input type="checkbox"/> Difficulty Responding to Questions Due to Memory or Confusion |
| <input type="checkbox"/> Violent or Aggressive Behavior | <input type="checkbox"/> Weakness or Coordination Problems |
| <input type="checkbox"/> Other | |

Please Explain Any Area That Was Marked: _____

Recommendation

- 5 Day Letter
- o Complete the Five-Day Letter.
 - o Retain documents in the issuing office for one year. They do not need to be sent to Medical Review Program.
- Forward to Medical
- o Mail or fax the completed form to Division of Motorist Services, Attention: Medical Review Program, Room A227, Neil Kirkman Building, Tallahassee, Florida 32399-0570, Fax (850) 617-3944.

Signature of Examiner/Agent User ID Date Signature of Supervisor/Manager User ID Date

Office Address Office Number