STATE OF FLORIDA DEPARTMENT OF HIGHWAY SAFETY AND MOTOR VEHICLES

MEDICAL REPORT

INSTRUCTIONS TO THE DRIVER: Please take this form to the physician most familiar with your medical history and the status of your medical condition(s).

Name: _____ Driver License #: _____

Date of Birth: _____ Telephone #: _____

INSTRUCTIONS TO THE PHYSICIAN: Please complete this form in its entirety. If a section does not apply, indicate "not applicable" or "N/A".

HISTORY:

1. How long have you known this patient? _____ Date of last office visit? _____
2. Other physicians the patient has seen in the past 2 years: _____

   _____
3. List any medical conditions or physical impairments the patient has: _____

   _____
4. List all prescribed medications: _____

   _____
5. Does the patient receive regular medical care? _____
6. Is patient reliable in taking medications? _____

SECTION 1 – NEUROLOGICAL

Does the patient have a history of epilepsy or convulsive seizures? _____

Date of last seizure of any type: _____

Medication and dosage for prevention: _____

Current anticonvulsant blood level: _____ Date taken: _____

If not in therapeutic range, please explain:_____

If medication discontinued, give date:_____ EEG? (Please attach a copy): _____

Please list any progressive neurological or neuromuscular disease: _____

_____

Please describe any physical activity limitations imposed by the condition: _____

_____

What is the status of the condition? _____ FSS/EDSS? (Please attach a copy): _____

Please list any neurological deficits due to CVA's, closed head injury, etc.: _____

_____

SECTION 2 – LOSS OF CONSCIOUSNESS/DIZZINESS

Does the patient have a history of blackouts, fainting spells, or dizziness? _____

Possible cause: _____ Frequency: _____ Date of last episode: _____

SECTION 3 – PSYCHIATRIC

Has the patient ever been admitted to a hospital or treated for mental or emotional illness?

_____

Facility: _____ Date of admission: _____ Date discharged: _____

Is the patient presently under treatment for, show evidence of, or have difficulty with any emotional problems or mental illness? _____

If yes, please attach a psychiatric report. _____

What is the status of the condition? _____

SECTION 4 – MENTAL/COGNITIVE

Is there any evidence of memory loss? _____

Any evidence of organic brain syndrome? _____

Any history of frequent or intermittent confusion? _____

If there are any cognitive deficits noted above, please provide the results of a Mini Mental State Exam (MMSE) or a Montreal Cognitive Assessment (MoCA):

_____

Education level of patient: _____

SECTION 5 –ALCOHOL AND DRUG

Is there any evidence or personal knowledge of addiction or abuse of alcohol or other drugs? _____

When and where has patient been treated for alcoholism or drug dependency:

_____

_____

Does the patient consume alcohol or drugs at this time? _____

To what extent? _____

If not, how long has the patient been alcohol and/or drug free: _____

SECTION 6 – DIABETES

What type of diabetes does the patient have? _____

How many times has patient been in diabetic ketoacidosis? _____

Date of last episode: _____

Frequency of hypoglycemic episodes involving LOC or near LOC: _____

Date of last episode: _____

How frequently have you seen this patient for control of patient's diabetes? _____

The physician's assessment of the control of the patient's diabetes: _____

_____

If uncontrolled, please explain: _____

SECTION 7 – CARDIAC

Please describe any cardiac problem the patient has that could interfere with driving:

_____

Please provide date of last episode of any LOC related to cardiac abnormalities or arrhythmias: _____

Please describe any treatment the patient is receiving: _____

_____

What is the status of the condition? _____

SECTION 8 – MUSCULOSKELETAL

Explain any limitation of motion, weakness, spasticity, or paralysis: _____

_____

What is the status of the condition? _____

Would adaptive equipment assist the patient with driving? _____

If yes, please describe: _____

_____

Has the patient completed a recent Certified Driver Evaluation (CDE)? _____

If yes, please attach copy: _____

SECTION 9 – SLEEP DISORDER

Please describe the frequency, severity, and treatment of the following sleep disorders: sleep apnea, narcolepsy, or insomnia: _____

_____

What is the status of the condition? _____

SECTION 10 – VISUAL

Visual acuity – Name of equipment used: _____

Without glasses: RE 20/ _____LE 20/ _____ BE 20/ _____

With glasses: RE 20/ _____LE 20/ _____ BE 20/ _____

Field of vision: RE _____ LE _____ BE _____

Does the patient use prism lenses to compensate for visual field loss? _____

PHSYCIAN'S RECOMMENDATION

Dear Doctor: The Department's Medical Advisory Board is charged with determining this individual's physical and mental ability to safely operate a motor vehicle. The information provided by you is vital in making this determination. In addition, we would like you to provide your opinion below as to whether or not this individual can operate a motor vehicle safely. This will be taken into consideration when rendering a decision in this case.

PLEASE ANSWER "YES" OR "NO" HERE:_____

PLEASE EXPLAIN YOUR ANSWER:

_____

_____

_____

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 #: _____

Classification or Specialty: _____

Address: _____

Telephone Number: _____

Date: _____