STATE OF FLORIDA
DEPARTMENT OF HIGHWAY SAFETY
AND MOTOR VEHICLES

Mental Status Examination Form

Name: _____ Date of Birth: ____ / ____/ _____

Driver License #: _____ Telephone #: _____

1. How long have you treated this client?

2. List other physicians who have treated the client in the past two years:

3. Brief history of illness for which you are treating the client:

4. General appearance, manner, attitude, and behavior:

5. Consciousness and sensorium:

6. Affectivity and mood:

7. Associations and thought processes - delusions, hallucinations, etc.:

8. Memory, recent and remote:

9. Calculation:

10. Fund of information:

11. Judgment and insight:

12. Personality maturity:

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Name: _____ Driver License #: _____

13. History of compliance with treatment:

14. Diagnosis:

15. Current medication and dosage:

16. Are you the physician prescribing the medications?

17. Please comment on the patient's past and current use of alcohol/drugs:

18. In your best judgment and relative to any psychiatric considerations, do you believe this individual can operate a motor vehicle safely? YES: _____ NO: _____

Comments: _____

_____

_____

When Completed, Please Mail 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 #: _____
Specialty: _____
Address: _____
Telephone Number: _____
Date: _____