



**STATE OF NORTH CAROLINA
DEPARTMENT OF TRANSPORTATION**

**ROY COOPER
GOVERNOR**

**J. ERIC BOYETTE
SECRETARY**

Instructions for Completing Medical Report

1. In order to be reviewed, the form must be signed and dated by you and your medical provider.
2. Take this form to a physician licensed to practice medicine in the State of North Carolina or any state of the United States for completion. Your physician will only need to complete the appropriate part(s) of this form that pertain to your health.
3. Please mail the completed form to the Division of Motor Vehicles Medical Review Unit, 3112 Mail Service Center, Raleigh, NC 27697-3112.

This information is required to determine your ability to safely operate a motor vehicle. Failure to submit the required medical information within 30 days from the date of this letter, will result in cancellation or denial of your driving privilege. If additional time is needed you may contact this office for consideration.

TELEPHONE (919) 861-3809

FAX (919) 733-9569

Mailing Address:
NC DIVISION OF MOTOR VEHICLES
MEDICAL REVIEW UNIT
3112 MAIL SERVICE CENTER
RALEIGH NC 27697-3112

Telephone: (919) 861-3809
Fax: (919) 733-9569

Location:
1100 NEW BERN AVE
RALEIGH NC

Website: www.ncdot.gov



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**North Carolina Division of Motor Vehicles
Driver License Section
Information Form**

Name: _____
Address: _____
City: _____
Customer No. _____

Dear CUSTOMER:

It has become necessary for the Medical Review Unit of the Division of Motor Vehicles to review your ability to continue to safely operate a motor vehicle.

The enclosed Medical Report Form should be completed by your physician and returned for evaluation. It is important that the Medical Report Form be completed and returned to the Medical Review Section to avoid cancellation of your driving privilege. In order to be reviewed, the form must be SIGNED AND DATED BY YOU AND YOUR MEDICAL PROVIDER.

Please give this matter your immediate attention in order to expedite your medical evaluation. If you have questions, you may contact us at (919) 861-3809 between 8:00 a.m. and 5:00 p.m. Monday through Friday.

Sincerely,

Director of Customer Compliance Services
Division of Motor Vehicles
Enclosures

Mailing Address:
NC DIVISION OF MOTOR VEHICLES
MEDICAL REVIEW UNIT
3112 MAIL SERVICE CENTER

Telephone: (919) 861-3809
Fax: (919) 733-9569
Customer Service: 1-877-368-4968

Location:
1100 NEW BERN AVE
RALEIGH NC

RALEIGH NC 27697-3112

Website: www.ncdot.gov

NORTH CAROLINA DIVISION OF MOTOR VEHICLES
DRIVER LICENSE SECTION
CONSENT/INFORMATION FORM

Name: _____

Address: _____

City: _____

Customer No. _____

Date of Birth _____ Race _____ Sex _____ County _____

I hereby authorize Dr./Counselor _____ to give any examination they deem necessary for the purpose of determining my physical fitness to operate a motor vehicle. I understand this authorization includes permission for this information to be reviewed by a medical advisor approved by the Division for the purpose of a recommendation to be rendered to determine my driving needs and abilities.

SIGNATURE OF APPLICANT: _____

PARENT/GUARDIAN IF MINOR: _____

Telephone No.: Home () _____ Business () _____

Are you Retired Disabled Occupation: _____

What type of vehicle do you drive? Automobile School Bus _____

Commercial Motor Vehicle Other _____

Does your job require driving? _____

To Physician

When completing the Medical Report Form, please keep in mind the physical, mental, and emotional requirements necessary for the safe operation of a motor vehicle, for the patient and public welfare. Please answer all questions and applicable parts of PP. 2-7, which lists the review of conditions pertinent to driving. If you circle "Yes" for any of these conditions, you should address all the questions pertaining on the proceeding pages. You do not need to answer questions on the form for which you circled "No". Upon completion of this form please make an overall statement about your patient's medical condition and its potential effect on safe driving.

CUSTOMER NO:

PATIENT'S MEDICAL HISTORY (Please complete in black ink):

A. If the patient has been hospitalized in the past two years, please give location, dates and discharge diagnoses. _____

B. How long has applicant been your patient? _____
Date you last treated patient before today? _____

C. Names of other physicians who have treated applicant in past two years: _____

D. What is patient's height? _____ weight? _____ B.P. _____

E. ARE YOU TREATING THIS PATIENT FOR ANY OF THE FOLLOWING MEDICAL CONDITION(S)? IF YES, PLEASE COMPLETE APPROPRIATE PAGE(S).

	YES	NO		YES	NO
VISUAL IMPAIRMENT?	_____	_____	EMOTIONAL/MENTAL ILLNESS?	_____	_____
If yes, p.3 to be completed by Optometrist or Ophthalmologist			If yes, complete entire section p.5		
CARDIOVASCULAR DISORDER?	_____	_____	MUSCULOSKELETAL DISORDER?	_____	_____
If yes, complete entire section p.4			If yes, complete entire section p.5		
ENDOCRINE DISORDER?	_____	_____	ANY OTHER IMPAIRMENT?	_____	_____
If yes, complete entire section p.4			If yes, complete entire section p.5		
RESPIRATORY DISORDER?	_____	_____	SUBSTANCE ABUSE PROBLEM?	_____	_____
If yes, complete entire section p.7			If yes, complete entire section p.6		
NEUROLOGIC DISORDER?					
If yes, complete entire section p.7					

F. TO BE ANSWERED BY PHYSICIAN LICENSED TO PRACTICE MEDICINE IN THE U.S.:

1. In your opinion, has the patient followed your medical recommendations?
Yes _____ No _____

2. Are periodic medical evaluations for highway safety purposes recommended for patient? Yes _____ No _____ If yes, how often? _____

3. Do you feel the patient is medically fit to drive a car? Yes _____ No _____

4. Do you feel the patient is medically fit to drive a CMV/SCHOOL BUS?
Yes _____ No _____

5. In your opinion, should patient be restricted to driving? If yes please specify _____ miles radius of home, 45 mph/no interstate, daylight driving only, hand controls, corrective lenses, left foot accelerator, wheel knob, accompanied by class driver, t/f wk/ch/md/store, etc.

6. Do you recommend a road test? Yes _____ No _____

7. Do you recommend an Occupational Therapist Evaluation? Yes _____ No _____

8. Has the driver been involved in a recent motor vehicle accident because of their medical conditions? _____

Give your overall assessment of this patient's medical condition and any potential effect on safe driving. Please comment on all medical conditions, and any over-the-counter or prescription medications that might exacerbate the risk of driving. _____

Physician's Signature: _____ MD, NP, PA Date of exam: _____

Print Physician Name: _____ Phone Number (____) _____

Physician's Specialty: _____

Address: _____ City/Zip: _____

CUSTOMER NO:

I, _____, hereby authorize Dr. _____ to provide my examination information for the purposes of determining my visual fitness to operate a motor vehicle. I understand this authorizes the Division's panel of physicians to review my case.

Applicant Signature _____ License/Cust No. _____
Parent/Guardian if Minor _____ Telephone Number _____

TO BE COMPLETED BY A LICENSED OPHTHALMOLOGIST OR OPTOMETRIST

1. What is the vision diagnosis? _____
2. Which eye(s) are affected? Right Left Both
3. Is the condition: Permanent Stable Worsening Improving
4. Best corrected Visual Acuity: 20/____ Both 20/____ Right 20/____ Left
5. Uncorrected Visual Acuity: 20/____ Both 20/____ Right 20/____ Left
6. New lenses prescribed? Yes No
7. Are corrective lenses recommended to drive? Yes No

8. What is the horizontal field of view in each eye w/out field expanders?
Right: nasal temporal Left: nasal temporal
Test used: Confrontation Goldmann Automated
9. Are there other visual issues that might affect driving?
 No Depth Perception Diplopia Contrast Sensitivity
 Glare sensitivity Other: _____
10. Is a bioptic telescope used for driving? Yes No (skip to #16)
11. If yes, how long has it been used? New Duration: _____ mo/yrs
12. If yes, for which eye(s)? (Circle) Right Left Both
13. Visual acuity through bioptic telescope: Right Left Both
14. Has the individual driven previously without a bioptic telescope? Y N
15. Has the individual completed training in the use of a bioptic for driving? Yes No
16. Are there any other concerns regarding this individual's fitness to safely operate a motor vehicle? No Cognitive Physical
 Psychological Other: _____
17. What driving restrictions (if any) do you recommend based upon your examination? None 45mph limit/no interstate Daylight Only
Local driving only: miles from home Should not drive
18. Other recommendations:
 Periodic vision evaluation: 6 months every: 1 2 3 years(s)
 On road evaluation by DMV (or approved examiner)
 Recommend DMV follow-up? Yes No
 Other: _____

Vision Examiner:

Name _____ Degree _____ License # _____
Address _____
Phone _____ Fax _____
Signature _____ Date of exam _____

CUSTOMER NO:

***** CARDIOVASCULAR *****

1. What is the diagnosis? _____
Date of onset: _____

2. Check AHA Cardiovascular Functional Class: I ___ II ___ III ___ IV ___

3. Does patient have arrhythmia that alters mental or physical functions?
Yes No If yes, how often? ___
What is the severity and does it cause syncope?
Is it controlled? Yes ___ No ___

4. Does patient currently use a pacemaker? Yes ___ No ___

5. Does the patient currently use an automatic implantable cardioverter-defibrillator? Yes ___ No ___ If yes, give date of surgery _____
Date(s) of hemodynamically significant arrhythmia events post-op: _____

6. Has the patient had cardiac surgery? Yes ___ No ___
Date and type of operation _____

7. Has the patient had CHF? Yes ___ No ___ Is CHF controlled? Yes ___ No ___

8. List current medications: _____

9. Assess compliance with medications: Excellent ___ Good ___ Poor ___

***** ENDOCRINE/DIABETES *****

1. What is the diagnosis? _____
Date of onset _____ HgbA1C Level _____ Therapy _____

2. If patient has experienced significant hypoglycemia in past year give dates of last episodes: _____

3. What is the patient's attitude toward treatment?
Accepts and complies ___ Non-compliant ___

4. Does the patient have any current or past systemic effects of diabetes and if so comment on its effect on driving? _____

5. Is the patient aware of the early warning signs of hypoglycemia and are reliable in taking necessary precautions to avoid hypoglycemia? Yes No

6. List current medications: _____

7. Assess compliance with medications: Excellent ___ Good ___ Poor ___

Physician's Signature: _____ Date _____

CUSTOMER NO:

***** MENTAL OR EMOTIONAL *****

1. What is the diagnosis? _____ Date of Onset _____
2. When and where was patient treated for this condition? _____
3. What is patient's current status? Recovered _____ Partially Controlled _____
Intermittently Controlled _____ Inadequately Controlled _____ Fully Controlled _____
4. Does patient have memory problems? Yes _____ No _____
If yes, to what degree? Mild _____ Significant _____ Severe _____
5. What is patient's mental capacity? Average or above _____
Below Average _____ Limited _____
6. Do you believe that this patient's mental or emotional illness poses a driving risk to himself/herself or others? Yes _____ No _____
7. List current medications: _____
8. Assess compliance with medications: Excellent _____ Good _____ Poor _____

***** MUSCULOSKELETAL *****

1. What is the diagnosis? _____ Date of Onset? _____
 2. Describe extent of impairment and prognosis _____
 3. Is it progressive? Yes _____ No _____
 4. Indicate percent of function (full range of motion equals 100%)
RIGHT ARM LEFT ARM RIGHT LEG LEFT LEG NECK
_____ % _____ % _____ % _____ % _____ %
 5. Indicate percent of strength (full range of motion equals 100%)
RIGHT ARM LEFT ARM RIGHT LEG LEFT LEG NECK
_____ % _____ % _____ % _____ % _____ %
 6. To what extent is coordination or reaction time impaired?
None _____ Slight _____ Moderate _____ Severe _____
 7. To what extent does patient's motion produce pain?
None _____ Slight _____ Moderate _____ Severe _____
 8. What spastic muscles does patient have? _____
 9. What extremities are missing? _____
 10. Do you recommend any assistive devices to compensate for your patient's disability? If so please advise: _____
 11. Do you recommend an Occupational Therapist Evaluation? Yes _____ No _____
 12. To what extent will the patient's musculoskeletal disorder impair driving? None _____ Slightly _____ Significantly _____ Should not drive _____
- REMARKS: _____

13. List current medications: _____
14. Assess compliance with medications: Excellent _____ Good _____ Poor _____

***** OTHER IMPAIRMENTS *****

1. Are there other medical impairments? Yes _____ No _____
If yes, describe: _____
2. List current medications: _____
3. Assess compliance with medications: Excellent _____ Good _____ Poor _____

Physician's Signature: _____ Date _____

CUSTOMER NO:

***** SUBSTANCE ABUSE *****

NOTICE: Recommendations for licensure for persons suspected of having substance abuse disorders will largely be made on the basis of their medical and other relevant records and documents.

1. Is the patient aware that driving with ANY amount of alcohol in their system is likely to affect driving performance and increase the risk of injury? Yes ___ No ___
2. Has the patient ever been charged with driving while impaired (DWI)? Yes ___ No ___ If yes, how many convictions? _____
3. At what age did the patient start drinking alcohol? _____
4. How often does (or did), patient drink?
Daily _____ Weekly _____ Monthly _____ Binge _____
5. How much does (or did), patient drink at a time?
1-2 drinks _____ 3-4 drinks _____ 5 or more drinks _____ Pint _____
6. How many times a year does (or did), patient drink enough to affect speech, walking, driving, or other activities? _____
7. Did the patient ever completely stop drinking? Yes ___ No ___
If yes, give the date(s) length of time stopped: _____
8. What was the date of patient's last drink (Beer, Wine, Whiskey)? _____
9. Has patient ever had a drinking problem? Yes ___ No ___
10. Does the patient believe that he/she can still drink without causing problems? Yes ___ No ___ If yes, why? _____
11. Has patient ever abused other drugs (illicit/prescription)? Yes ___ No ___
If yes, give drugs and describe extent of usage: _____
12. Describe patient's current use of drugs and/or medications: _____
13. When did patient last abuse drugs? _____
14. Which of the following types of substance abuse education, treatment, or rehabilitation programs has patient SUCCESSFULLY COMPLETED?
____ ADETS (Alcoh. Drug Ed. Traffic Sch.) Dates: _____ to _____
____ Alcohol Rehabilitation Center Dates: _____ to _____
Name: _____
____ Mental Health Program Dates: _____ to _____
____ Alcoholics Anonymous Dates: _____ to _____ Sponsor? Yes ___ No ___
Approximate number of sessions: _____
____ None: The patient did not complete a substance abuse program.
15. Have you recommended that this patient seek help? Yes ___ No ___
16. Is patient actively involved in any social or other type of health aid program such as mental health, private counseling, Alcoholics Anonymous, etc.? If yes, please complete the following:
Name of program: _____
Address: _____ Telephone: (____) _____
17. Does the patient have sufficient support for maintaining sobriety?
___ Yes ___ No
18. Is the patient using Methodone or Naltraxone? ___ Yes ___ No

Physician's Signature: _____ Date _____

CUSTOMER NO:

***** RESPIRATORY *****

1. What is the diagnosis? _____
Medications _____
2. What is the degree of severity? Mild _____ Moderate _____
Severe (paO2<60mmHg) _____ Debilitating _____

**NOTE: IF paO2 IS LESS THAN 60mmHg, PLEASE OBTAIN AND ATTACH ROOM AIR ARTERIAL BLOOD GAS IF NOT CONTRAINDICATED.

3. Does patient use oxygen while driving? Yes _____ No _____
4. Oxygen saturation levels _____
5. Does patient use a CPAP machine? Yes _____ No _____

NOTE: If Physician checked "YES" to question #5 please attach a copy OF YOUR CPAP COMPLIANCE REPORT FOR THE LAST YEAR

***** NEUROLOGIC *****

1. What is diagnosis? _____
Date of onset: _____
2. Has patient suffered brain damage from trauma, cerebrovascular disease, stroke, or other cause? Yes _____ No _____ Has it resolved? _____
3. Has patient suffered impairment of any of the following:
Mentation? Yes _____ No _____ Memory? Yes _____ No _____
Judgment? Yes _____ No _____ Emotional Stability? Yes _____ No _____

**NOTE: IF YOU CHECKED "YES" TO ANY OF THE ABOVE CATEGORIES, COMPLETE THE EMOTIONAL PORTION OF THIS FORM ON PG 5.

4. Has patient suffered impairment of any of the following:
Muscular strength? Yes _____ No _____ Coordination? Yes _____ No _____

**NOTE: IF YOU CHECKED "YES" TO ANY OF THE ABOVE CATEGORIES, COMPLETE THE MUSCULOSKELETAL PORTION OF THIS FORM ON PG 5.

5. If patient has seizure disorder, what type? _____
With seizure, is there any loss of consciousness? Yes No _____
Date of onset: _____ Number of seizures in last 2 yrs: _____
Date of last: _____ Aura? If yes, duration: _____
Does the seizure occur during sleep only? Yes _____ No _____
6. Is patient taking medication for his/her epilepsy or seizures?
Yes _____ No _____ If yes, complete the following:
List medications and dosage _____
Date of last medication change _____ Blood _____ levels
Date medication was discontinued _____ Who discontinued _____
Compliance with medication: Excellent _____ Good _____ Poor _____
7. Has the patient had an EEG: Yes _____ No _____ If yes, when: _____
Interpretation: _____
8. Have there been other episodes of altered consciousness? Yes _____ No _____
If yes, give date, description and work-up: _____

Physician's Signature: _____ Date _____

00 No physician-diagnosed disease of consequence
08 Automatic implantable cardioverter-defibrillator
11 Hypertension
12 Cardiovascular disorder
13 Valvular heart disease
14 Cerebrovascular accident(s)
15 Cardiac arrhythmias(s)
16 Peripheral vascular disease
17 Heart failure
18 Pacemaker
19 Cardiac surgery
20 Insulin-dependent Diabetes
21 Non-insulin-dependent Diabetes
22 Peripheral Neuropathy
25 Endocrine disorder(s)
30 Loss of consciousness or dizziness
31 Seizure disorder
32 Sleep disorder(s)
33 Multiple sclerosis
34 Parkinson's disease
35 Neuromuscular Disease
36 Non-Muscular Dystrophy Neuromuscular Disorder
37 Cerebral vascular malformations
38 Cerebral palsy
39 Paralysis - complete
40 Paralysis - partial
41 Traumatic brain injury
42 Brain neoplasm or tumor
45 Arthritis
46 Missing limb(s)
47 Neck or back pain
48 Musculoskeletal Impairment(s)
50 Hearing impairment
53 Homonymous Hemianopia
54 Biotopic Telescope Lenses
55 General Eye Condition
56 Corneal Impairment
57 Visual Field Impairment
58 Retinal Impairment
59 Nystagmus
60 Mental Health Condition
61 Psychotic Disorder
62 Mood Disorder
63 Anxiety disorders
64 Personality disorder
65 ALCOHOL-RELATED - ALL CASES CODED PRIOR TO 7/1/69
66 Alcohol misuses-no record of DWI
67 Alcohol misuse-DWI 18 months ago or more
68 Alcohol misuse-DWI less than 18 months
70 Substance use, misuse, or abuse
75 Intellectual or Developmental Disability
76 Encephalopathy
77 High risk driver
78 Cognitive Impairment
79 Emotional Disability

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- 80 Respiratory disorders
- 90 Miscellaneous disease or impairment
- 91 Renal Disorder
- 92 Skin Disorder
- 93 Gastrointestinal Disorder
- 94 Genitourinary Disorder
- 95 Neurological Disorder
- 99 General Physical Condition