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
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
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 ______ Occupations: ______________
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

   VISUAL IMPAIRMENT? ______ EMOTIONAL/MENTAL ILLNESS? ______   YES   NO
   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: ________________________ City/Zip: ________________________
Address: ________________________
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: ___________Both ___________Right ___________Left
5. Uncorrected Visual Acuity: ___________Both ___________Right ___________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/ys
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?___________________________  HgbA1C Level_______  Therapy________
   Date of onset____________________

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 __________
   If yes, to what degree? Mild____ Significant____ Severe ______
4. What is patient's mental capacity? Average or above________________________
   Below Average ____________________
5. Do you believe that this patient's mental or emotional illness poses a
   driving risk to himself/herself or others? Yes____ No____
6. List current medications: ________________________________________________
7. 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 (DUI)? 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 _______
   ____ Alcohols 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 Methadone 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 (pa02<60mmHg) _____ Debilitating _____
   **NOTE: IF pa02 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? YesNo________
   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
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<thead>
<tr>
<th>No.</th>
<th>Description</th>
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<tbody>
<tr>
<td>00</td>
<td>No physician-diagnosed disease of consequence</td>
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<tr>
<td>08</td>
<td>Automatic implantable cardioverter-defibrillator</td>
</tr>
<tr>
<td>11</td>
<td>Hypertension</td>
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<tr>
<td>12</td>
<td>Cardiovascular disorder</td>
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<tr>
<td>13</td>
<td>Valvular heart disease</td>
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<tr>
<td>14</td>
<td>Cerebrovascular accident(s)</td>
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<td>15</td>
<td>Cardiac arrythmias(s)</td>
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<td>16</td>
<td>Peripheral vascular disease</td>
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<td>17</td>
<td>Heart failure</td>
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<td>18</td>
<td>Pacemaker</td>
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<td>19</td>
<td>Cardiac surgery</td>
</tr>
<tr>
<td>20</td>
<td>Insulin-dependent Diabetes</td>
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<td>21</td>
<td>Non-insulin-dependent Diabetes</td>
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<tr>
<td>22</td>
<td>Peripheral Neuropathy</td>
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<td>25</td>
<td>Endocrine disorder(s)</td>
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<td>30</td>
<td>Loss of consciousness or dizziness</td>
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<td>31</td>
<td>Seizure disorder</td>
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<td>32</td>
<td>Sleep disorder(s)</td>
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<td>33</td>
<td>Multiple sclerosis</td>
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<td>34</td>
<td>Parkinson's disease</td>
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<td>35</td>
<td>Neuromuscular Disease</td>
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<tr>
<td>36</td>
<td>Non-Muscular Dystrophy Neuromuscular Disorder</td>
</tr>
<tr>
<td>37</td>
<td>Cerebral vascular malformations</td>
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<td>38</td>
<td>Cerebral palsy</td>
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<td>39</td>
<td>Paralysis - complete</td>
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<tr>
<td>40</td>
<td>Paralysis - partial</td>
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<tr>
<td>41</td>
<td>Traumatic brain injury</td>
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<tr>
<td>42</td>
<td>Brain neoplasm or tumor</td>
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<tr>
<td>45</td>
<td>Arthritis</td>
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<tr>
<td>46</td>
<td>Missing limb(s)</td>
</tr>
<tr>
<td>47</td>
<td>Neck or back pain</td>
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<td>48</td>
<td>Musculoskeletal Impairment(s)</td>
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<tr>
<td>50</td>
<td>Hearing impairment</td>
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<td>53</td>
<td>Homonymous Hemianopia</td>
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<td>Bioptic Telescope Lenses</td>
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<td>General Eye Condition</td>
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<td>Corneal Impairment</td>
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<td>Visual Field Impairment</td>
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<td>Retinal Impairment</td>
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<td>Nystagmus</td>
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<td>Mental Health Condition</td>
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<td>Psychotic Disorder</td>
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<td>Mood Disorder</td>
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<td>63</td>
<td>Anxiety disorders</td>
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<tr>
<td>64</td>
<td>Personality disorder</td>
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<tr>
<td>65</td>
<td>ALCOHOL-RELATED - ALL CASES CODED PRIOR TO 7/1/69</td>
</tr>
<tr>
<td>66</td>
<td>Alcohol misuses-no record of DWI</td>
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<tr>
<td>67</td>
<td>Alcohol misuse-DWI 18 months ago or more</td>
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<tr>
<td>68</td>
<td>Alcohol misuse-DWI less than 18 months</td>
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<tr>
<td>70</td>
<td>Substance use, misuse, or abuse</td>
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<tr>
<td>75</td>
<td>Intellectual or Developmental Disability</td>
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<td>76</td>
<td>Encephalopathy</td>
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<td>High risk driver</td>
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<td>Cognitive Impairment</td>
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<td>Emotional Disability</td>
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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