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.
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 ( ) 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
   VISUAL IMPAIRMENT? ___________ EMOTIONAL/MENTAL ILLNESS? ___________ 
   If yes, p.3 to be completed by Optometrist or Ophthalmologist 
   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: ____________________________
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/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: 

************************************************************************** CARDOVASCULAR **************************************************************************

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____
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________________
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:

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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 Methadone or Naltraxone? Yes ___ No ___

   Physician's Signature: __________ Date __________

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CUSTOMER NO:

PDF: RESPIRATORY

1. What is the diagnosis?  
   Mediations

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**

PDF: 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:  
   Date of last:  
   Number of seizures in last 2 yrs:  
   Does the seizure occur during sleep only?  Yes___  No _____  Aura? If yes, duration:

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
   Date medication was 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  __________________
No physician-diagnosed disease of consequence

Automatic implantable cardioverter-defibrillator

Hypertension

Cardiovascular disorder

Valvular heart disease

Cerebrovascular accident(s)

Cardiac arrhythmias(s)

Peripheral vascular disease

Heart failure

Pacemaker

Cardiac surgery

Insulin-dependent Diabetes

Non-insulin-dependent Diabetes

Peripheral Neuropathy

Endocrine disorder(s)

Loss of consciousness or dizziness

Seizure disorder

Sleep disorder(s)

Multiple sclerosis

Parkinson's disease

Neuromuscular Disease

Non-Muscular Dystrophy Neuromuscular Disorder

Cerebral vascular malformations

Cerebral palsy

Paralysis – complete

Paralysis – partial

Traumatic brain injury

Brain neoplasm or tumor

Arthritis

Missing limb(s)

Neck or back pain

Musculoskeletal Impairment(s)

Hearing impairment

Homonymous Hemianopia

Bioptic Telescope Lenses

General Eye Condition

Corneal Impairment

Visual Field Impairment

Retinal Impairment

Nystagmus

Mental Health Condition

Psychotic Disorder

Mood Disorder

Anxiety disorders

Personality disorder

ALCOHOL-RELATED – ALL CASES CODED PRIOR TO 7/1/69

Alcohol misuses-no record of DWI

Alcohol misuse-DWI 18 months ago or more

Alcohol misuse-DWI less than 18 months

Substance use, misuse, or abuse

Intellectual or Developmental Disability

Encephalopathy

High risk driver

Cognitive Impairment

Emotional Disability
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