



PAT McCRORY
Governor

NICHOLAS J. TENNYSON
Secretary

**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.

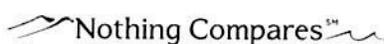
The enclosed Medical Report Form should be completed by your physician and returned to the Division. It is important that this document be completed and returned to the Medical Review Unit within 30 days from the date of this letter to avoid cancellation of your driving privilege. In order to be reviewed, 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 additional questions, please contact us at (919) 861-3809 between 8:00 a.m. and 5:00 p.m. Monday through Friday.

Sincerely,

A handwritten signature in black ink, appearing to read 'JR Zimmerman', with a long horizontal flourish extending to the right.

Jeffrey R. Zimmerman, Ph.D.
Director of Processing Services
Division of Motor Vehicles





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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 27699-3112.

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





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

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 pages 2-7, which list your view 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	_____	_____	If yes, complete entire section p.5	_____	_____
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 a 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: _____

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 corrected 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/yr
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 _____

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 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.
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.
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 _____
Interpretation: _____
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 data, 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 - (CAD,MI,HCVD,OTHER)
- 13 Valvular heart disease and all congenital heart diseases
- 14 Cerebrovascular accidents (including ruptured aneurysms, etc.)
- 15 Cardiac arrhythmias
- 16 Peripheral vascular disease (non-cerebral)
- 17 Congestive heart failure
- 18 Pacemaker
- 19 Cardiac surgery-coronary by-pass,angioplasty, valvular replacement, etc.
- 20 Diabetes Mellitis, treated with insulin
- 21 Diabetes Mellitis, not treated with insulin
- 22 Diabetic Peripheral Neuropathy
- 25 Other endocrine disorders
- 30 Blackout spells, syncope, dizziness, vertigo, etc.
- 31 Seizure disorder (all types) - Grand mal, petit mal, ETC.
- 32 Narcolepsy, sleep apnea, and related disorders
- 33 Multiple sclerosis
- 34 Parkinson's disease
- 35 Other acquired neuromuscular disease (muscular dystrophy, other)
- 36 Other congenital neuromuscular disease (spina bifida, other)
- 37 Cerebral vascular malformations (A-V malformations, aneurysms, etc.)
- 38 Cerebral palsy
- 39 Paralysis - complete or partial, 2nd to trauma (CNS, cord injury, etc.)
- 40 Paralysis, complete or partial, of any other etiology
- 41 Head and/or brain trauma, sub-dural hematoma, etc.
- 42 Brain neoplasm or tumor (including acquired hydrocephalus)
- 45 Arthritis, rheumatism and bursitis
- 46 Absent extremity(ies) or part(s) thereof
- 47 Non-paralytic back impairments (including cervical spine)
- 48 Other impairments involving bones, joints, and/or muscles
- 50 Hearing impairments
- 55 Visual defects-general (macular degeneration, amblyopia, trauma, other)
- 56 Cataracts (incl post op), corneal scars, Fuch's corneal dystrophy, etc.
- 57 Visual field changes (including optic atrophy, glaucoma, retinitis, etc)
- 58 Retinitis pigmentosa, Sagarts's Retinitis
- 59 Nystagmus
- 60 Emotional or mental illness (simple depression, other)
- 61 Schizophrenia and schizoid disorders - paranoid,chronis,undifferentiated
- 62 Bi-polar disorders (manic and/or depressive) with/without psychosis
- 63 Neurotic disorders (anxiety,panic,hysteria,conversion,phobias)
- 64 Personality disorder (borderline,passive aggressive,other)
- 65 ALCOHOL-RELATED - ALL CASES CODED PRIOR TO 7/1/69
- 66 Alcohol related-no record of DWI or evidence of drinking while driving
- 67 Alcohol related-convicted DWI or evid drink whl driv, abstinent 18 mos
- 68 Alcohol related-convicted DWI or evid drink whl driv, NOT abstain 18 mos
- 70 Illegal and/or improper drug use contraindicatind driving
- 75 Mental deficiency
- 76 Organic brain syndrome (of any etiology)
- 77 Poor driving ability, high risk driver
- 78 Alzheimer's disease
- 80 Respiratory disorders
- 90 Miscell diseases/impairments(specify-renal, anemia, cancer,obesity,etc)
- 99 General Physical Condition