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
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 Processing Services

Enclosures

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
Customer Service: 1-877-368-4968

Website: www.ncdot.gov
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 Opthamologist
   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/hrs
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 ______-3-______
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 _______________________________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 ____________________________
   4-
CUSTOMER NO:

1. **MENTAL OR EMOTIONAL**
   - What is the diagnosis? __________________ Date of Onset ____________
   - When and where was patient treated for this condition? __________

2. What is patient's current status? Recovered ___ Partially Controlled ___
   Intermittently Controlled ___ Inadequately Controlled ___ Fully Controlled ___

3. Does patient have memory problems? Yes ___ No ___
   If yes, to what degree? Mild ___ Significant ___ Severe ___

4. What is patient's mental capacity? Average or above ___
   Below Average ___ Limited ___

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 ___

1. **MUSCULOSKELETAL**
   - What is the diagnosis? __________________ Date of Onset? ____________
   - 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 ___

1. **OTHER IMPAIRMENTS**
   - 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 __________

-5-
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 __________
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 -7-
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 Bioptic 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
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