MEDICAL REPORT
FOR

DOT-H 2058 (4/09)

_____
Applicant's Name

NOTICE TO APPLICANT:
Please take this form to your doctor (licensed M.D. or D.O.). You are responsible for any expense involved.

The Medical Advisory Board will review your medical report that will be identified by number only. The board will provide an opinion regarding your fitness to drive safely based on the guidance in the Medical Conditions Affecting Drivers.

The County's Examiner of Drivers will review the board's opinion and decide whether you meet the standards required to operate a motor vehicle in the State of Hawaii.

NOTICE TO MEDICAL EXAMINER:
This applicant is required to undergo a medical examination to provide the driver licensing administrator information to decide whether the physical and mental standards to be licensed in this State are met. Your report will be reviewed by this agency and the Medical Advisory Board before the applicant is licensed. State laws make the licensing administrator responsible for the licensing action and your medical report is strictly advisory. Please be assured that your report will be used to grant driving privileges commensurate with driving ability while considering driving need and public safety.

Please complete the form for the medical condition in question so that we may be properly informed about the medical conditions that might impair safe driving ability. If your examination reveals other conditions that in your professional opinion might present a hazard to driving safely, please provide the information. Consult with other medical authorities, if necessary.

The applicant is responsible for any professional fee for this examination. The AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION form is for your protection; it should be signed by the applicant and kept in your files.

Thank you for your assistance in this program.

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the release of my medical history to the county examiner of drivers for deciding my eligibility for

a driver's license by._____.
Name of M.D. or D.O.

_____
Signature of applicant Date

DRIVER'S LICENSE NUMBER_____ CASE NUMBER_____

Class_____ Restriction_____ Driver's name_____ Age_____ Tel number_____

Occupation_____ Reason for medical report_____

I. MEDICAL HISTORY - Complete all items.

Yes No

☐ ☐ A. Does your patient have a physical, neurological, or mental impairment that might impair safe driving?

B. What is the diagnosis of your patient's illness or injury?

_____

_____

_____

C. How long have you treated this patient?_____

When was the most recent visit?_____

D. What medication(s) is the patient taking? Name drugs. How often?

DRUG DOSE SCHEDULE

_____

_____

_____

II. MEDICAL CONDITIONS - Complete problem areas only.

Yes No

☐ ☐ A. CARDIAC/PULMONARY - Initial ____ if not applicable and skip this section.

1. Vital signs: BP_____ P_____ RR_____

☐ ☐ Edema?

☐ ☐ Supplemental oxygen needed?

☐ ☐ 2. Does patient have chest pain (angina) or obvious dyspnea?
If yes, describe for "at rest", "slight exertion", or "moderate."

_____

_____

☐ ☐ 3. Does patient have any of the following: syncope, vertigo, infarction?
If yes, give details.

_____

_____

_____

☐ ☐ 4. Does patient take medication regularly for cardiovascular condition?
If yes, explain.

_____

_____

_____

5. Describe any cardiac assistive device, e.g. pacemaker, and give implant date.

_____

6. Describe patient's functional capacity (AMA):

Class 1 No limitation physical activity _____

Class 2 Slight limitation physical activity _____

Class 3 Marked limitation physical activity _____

Class 4 Complete limitation physical activity _____

DRIVER'S LICENSE NUMBER_____CASE NUMBER_____

Yes No

☐ ☐ B. DIABETES - Initial ____ if not applicable and skip this section.

☐ ☐ 1. Is patient being treated for diabetes?
If yes, specify insulin dosage and type or oral medication dosage and type.

_____

_____

☐ ☐ 2. Is there a history of hypoglycemic reactions?

☐ ☐ If yes, is there any warning of reactions?

☐ ☐ If no, does the patient check his/her own blood sugar, using a glucose meter, before driving?

☐ ☐ 3. If taking insulin, or oral medication, does the patient carry glucose tablets or candy at all times?

☐ ☐ 4. Is diabetes under control?

_____

_____

☐ ☐ C. NEUROLOGICAL - Initial ____ if not applicable and skip this section.

☐ ☐ 1. Does your patient have a history of seizures, syncopal attacks, or disabling dizziness?

2. What is the frequency of these episodes?_____
When was the last episode?_____

☐ ☐ 3. Does your patient presently have any neurological impairment?
If so, please detail.

_____

_____

_____

☐ ☐ 4. Do you expect the patient will be free of seizures in the future?

☐ ☐ D. ORTHOPEDIC - Initial ____ if not applicable and skip this section.

☐ ☐ 1. Does the patient have an amputation or skeletal defect that can interfere with driving ability? If yes, give details.

_____

_____

_____

_____

☐ ☐ 2. Does the patient use an artificial limb? If yes, explain.

_____

_____

☐ ☐ 3. Has the patient any paralysis, joint stiffness, reduced physical dexterity, or limitation of motion sufficient to interfere with driving safely? If yes, give details.

_____

_____

_____

☐ ☐ 4. Is condition stable?

DRIVER'S LICENSE NUMBER_____CASE NUMBER_____

Yes No

☐ ☐ E. MENTAL HEALTH - Initial ____ if not applicable and skip this section.

☐ ☐ 1. In the past three years, has the patient demonstrated hallucinations, delusions, drinking, drug abuse, impulsive, assaultive, homicidal, or suicidal behavior or other symptoms or signs indicating treatment was needed? Please list.

_____

_____

_____

☐ ☐ 2. In the past three years, have treatment recommendations been followed? Describe hospitalizations, residential, OPD, psychotherapy, medication, AA, NA, anger management.

_____

_____

_____

3. Current diagnosis.

_____

_____

4. Current treatment.

_____

_____

☐ ☐ F. ALCOHOL/SUBSTANCE ABUSE - Initial ____ if not applicable and skip this section.

☐ ☐ 1. Does your patient have a history of:

☐ ☐ Alcohol abuse?

☐ ☐ Stimulants (cocaine, methamphetamine) abuse?

☐ ☐ Others? If yes, specify. _____

☐ ☐ 2. Is your patient being treated for alcohol/substance abuse?
Date(s) of last use of alcohol. _____
Date(s) of last use of other substances (marijuana, cocaine, methamphetamine)._____

☐ ☐ 3. Is your patient currently clean and sober? If yes, for how long? _____

☐ ☐ 4. Does your patient go to AA/NA meetings three times per week?

☐ ☐ 5. If you are not treating this patient for alcohol/substance abuse, is the patient seeing:

☐ ☐ A certified substance abuse counselor?

☐ ☐ A psychologist?

☐ ☐ A psychiatrist (physician)?

☐ ☐ G. VISION - Initial ____ if not applicable and skip this section.

1. Visual Acuities:

☐ ☐ a. Are there medical conditions or medications that could affect patient's visual acuities?
If yes, list conditions: _____

_____

b. Distance Visual Acuities:

	Uncorrected	Corrected with present lenses
Right eye	20/	20/
Left eye	20/	20/

Yes No

DRIVER'S LICENSE NUMBER_____CASE NUMBER_____

2. Visual Fields:

☐ ☐ a. Are there medical conditions that could affect patient's visual fields?

b. If yes, list condition(s) and either attach a copy of visual fields testing, or fill in the amount of visual fields in each eye.

Condition(s):_____

_____

Right eye:_____degrees Left eye:_____degrees

☐ ☐ H. HEARING - Initial ____ if not applicable and skip this section.

☐ ☐ 1. Does patient have a hearing problem? If yes, describe.

_____

_____

III. CONCLUSION – Complete all items.

Yes No

☐ ☐ **A. *AT PATIENT'S LAST VISIT, WAS PATIENT'S CONDITION OR MEDICATIONS LIKELY TO INTERFERE WITH SAFE DRIVING?**

☐ ☐ **B. *IN YOUR OPINION, IS THIS PERSON CAPABLE OF SAFE DRIVING?**

☐ ☐ **C. *DO YOU RECOMMEND A ROAD TEST?**

D. *IN YOUR OPINION, HOW OFTEN SHOULD THIS PERSON'S DRIVING ABILITY BE REEVALUATED BY THE DMV? Every _____ year(s)

E. *WHAT RENEWAL PERIOD DO YOU RECOMMEND FOR THIS DRIVER? (License terms: Age 16-19 = 6-month provisional license until 19; 17-24 = 4 years; 25-71 = 8 years; 72+ = 2 years.) **_____ year(s)**

*These items must be completed.

I certify that I have examined this applicant.

Print name of reporting physician Check one: ☐ MD ☐ DO	Date of examination	Office telephone number
Signature of reporting physician **X**	Medical license number	Specialty