



GEORGIA DEPARTMENT OF DRIVER SERVICES
MEDICAL REPORT

PATIENT INSTRUCTIONS

IMPORTANT:

- 1. Complete, date, and sign page 1 of this report.
2. Give pages 1-4 to your licensed physician.
3. The physician must complete, date, and sign pages 2-4.
4. All pages of this report MUST be mailed or faxed (with coversheet) by a licensed physician directly to:

Department of Driver Services
Medical Review Unit
P. O. Box 80447
Conyers, Georgia 30013 or
Fax to (770) 344-3629

PATIENT INFORMATION

Name: Last First MI DOB (mm/dd/yyyy):
Physical Street Address:
City State Zip Code Driver's License #

PATIENT HISTORY

Please check "Yes" or "No" to each of the following questions. Explain each "yes" answer if your ability to drive is OR could be affected.

Table with 2 columns: Yes, No. Rows include: Physical impairments, Driver's license has ever been revoked or denied, Neurological problems or diseases, Head or spinal injuries, Seizures, fits, blackouts, convulsions, or fainting spells, Nervous, mental or psychiatric problems or diseases, Cardiovascular problems or diseases, Orthopedic, musculoskeletal, bone, joint or muscle problems or diseases, Diabetes, Visual problems or diseases, Hearing problems.

Explain any "Yes" answer(s):

PATIENT ATTESTATION

I hereby swear or affirm that the above answers are true to the best of my knowledge. I authorize _____, a licensed physician, to complete this examination and to provide further clarification or information about my medical condition to the Georgia Department of Driver Services (DDS). I agree that this Medical Report may be submitted to the DDS Driver's License Advisory Board, which consists of doctors licensed to practice throughout the State of Georgia, and that it may also be used for the guidance of the courts when necessary.

Driver/Licensee Signature

Date

MEDICAL REPORT PHYSICIAN'S STATEMENT

GENERAL INFORMATION:

- 1. How long has this individual been under your care as a patient? Years: _____ Months: _____
- 2. When did you last examine this patient? Year: _____ Month: _____
- 3. Does this patient have a problem, condition, disorder or disease that could affect his or her ability to drive safely?
 Yes No If 'Yes', please explain: _____
- 4. Does this patient require adaptive equipment in order to drive? Yes No If 'Yes', please explain:

- 5. What is your diagnosis? _____

*****IMPORTANT: Questions 6 and 7 REQUIRE a 'YES' or 'NO' answer.*****

- 6. Do you find any difficulties, problems, or diseases, other than 1 through 5 above, which would interfere with this person's ability to safely operate a motor vehicle? Yes No If 'yes', please explain:

- 7. In your opinion, is this patient medically capable of safely operating a motor vehicle? Yes No If no, please explain:

SECTION A

NEUROLOGICAL, CEREBROVASCULAR, ALTERATION IN CONSCIOUSNESS

- A. 1. Does patient have a history of blackouts or fainting spells? Yes No
 If yes, how often? _____ Date of last occurrence: _____
 Was this a one-time episode? Yes No If yes, state the cause. _____
- A. 2. Has patient had seizures associated with epilepsy? Yes No
 If 'yes', date of onset and history: _____
 What is the Frequency: _____ Date of last occurrence: _____
- A. 3. Has patient had convulsive seizures not associated with epilepsy? Yes No
 If 'yes', date of onset and history: _____
 What is the Frequency: _____ Date of last occurrence: _____
- A. 4. Is patient compliant with medication regiment? Yes No
- A. 5. Should patient continue taking medication? Yes No
- A. 6. Was an electroencephalogram performed? Yes No (If yes, please attach copy of EEG report.)
- A. 7. Parkinson's disease? Yes No Coordination normal? Yes No Vertigo? Yes No
 Explain any 'Yes' answers for question A.7. _____
- A. 8. Any other neurological or cerebrovascular conditions which could affect patient's ability to safely operate a motor vehicle?
 Yes No
 If 'yes', please explain: _____

If this box is checked, a neurological evaluation report must be made by a neurosurgeon or neurologist and attached to this report.

SECTION B

CARDIOVASCULAR, RESPIRATORY OR HYPERTENSIVE DISEASE

Functional Capacity (American Heart Association (AHA)):

- Class 1: No limitation physical activity
- Class 2: Slight limitation physical activity
- Class 3: Marked limitation physical activity
- Class 4: Complete limitation physical activity

- B. 1.** Functional capacity classification (Check one): Class 1 Class 2 Class 3 Class 4
- B. 2.** Blood pressure: _____
- B. 3.** Edema: Yes No
- B. 4.** Dyspnea and/or angina? Yes No At rest? Yes No Slight exertion? Yes No Moderate? Yes No
- B. 5.** Any syncope? Yes No If 'yes', please indicate frequency and severity:

- B. 6.** Any syncopal episodes in the past 12 months? Yes No If 'yes', please explain:

- B. 7.** Was last syncopal episode related to cardiovascular abnormalities or arrhythmias? Yes No
 If 'yes', please explain: _____

- B. 8.** Any other findings or cardiovascular, respiratory, or hypertensive problems which could affect patient's ability to safely operate a motor vehicle?
 If 'yes', please explain: _____

SECTION C

NERVOUS, MENTAL, PSYCHIATRIC, PSYCHOLOGICAL

- C. 1.** Any nervous, mental, psychiatric or psychological problem that could impair driving ability? Yes No
 If 'yes', please explain: _____

- C. 2.** Memory within normal limits? Yes No
- C. 3.** History of frequent or intermittent confusion? Yes No
- C. 4.** Any evidence of organic brain syndrome? Yes No
- C. 5.** Any other findings or nervous, mental psychiatric or psychological which could affect patient's ability to operate a motor vehicle safely? Yes No
 If 'yes', please explain: _____

If this box is checked, a psychiatric evaluation report must be made by a psychiatrist or psychologist and be attached to this report, with recommendations.

SECTION D

ORTHOPEDIC, MUSCULOSKELETAL

- D. 1. Explain any limitation of motion: _____

- D. 2. Any stiff or flail joints? Yes No
- D. 3. Any spastic or paralyzed muscles? Yes No If 'yes', where? _____
- D. 4. Does patient use or need orthopedic appliances or supports? Yes No If 'yes', please explain: _____
- D. 5. Any other orthopedic or musculoskeletal findings which could affect patient's ability to safely operate a motor vehicle?
 Yes No If 'yes', please explain: _____

SECTION E

DIABETES

- E. 1. Age at onset: _____
- E. 2. Is diabetes well-controlled? Yes No Please explain response: _____
- E. 3. Has patient ever been in a diabetic coma? Yes No If 'yes', date of last coma: _____
Warning symptoms? _____
- E. 4. Has patient ever had an episode involving loss of consciousness or near-loss of consciousness? Yes No
If 'yes', please explain cause and date of last episode: _____

SECTION F

MEDICATION

- F. 1. Is the patient prescribed medication? Yes No
- F. 2. If 'yes', is the patient taking medication as prescribed? Yes No
If 'yes', please indicate name, dosage and frequency for each medication: _____

If 'no', please describe medications the patient is not compliant with: _____

PHYSICIAN ACKNOWLEDGEMENT

Name of Practice _____
 Physician Full Name: Last: _____ First: _____ M.I. _____
 Physician Specialty: _____
 License Number/State: _____
 Physician Address: _____
 City: _____ State: _____ Zip: _____
 Physician Telephone Number: _____ - _____ - _____

Physician Signature

Date