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** of this report and a copy of the DDS letter that lists the medical concern(s) to your licensed physician.
3. The physician must complete **pages 2-4**; sign and date **page 4**.
4. All drivers who wish to maintain a **Commercial Driver's License** MUST have this form completed by a medical provider on the approved Federal Motor Carrier Safety Administration (FMCSA)National Registry of Certified Medical Examiners. (https://www.fmcsa.dot.gov).
5. **All pages** of this report and a copy of the DDS letter MUST be mailed by the medical provider directly to:

Department of Driver Services
Medical Review Unit
PO Box 80447
Conyers, Georgia 30013

PATIENT INFORMATION

Name: Last _____ First _____ MI _____ DOB (mm/dd/yyyy) _____

Physical Street Address _____

City _____ State _____ Zip Code _____ Driver's License # _____

Please check the box next to the class of license you hold:

Non-Commercial Class: C/CP ☐ M/MP ☐ D ☐

Commercial Class: A/AP ☐ B/BP ☐ C ☐

PATIENT HISTORY

Please check "Yes" or "No" to indicate any conditions you have that could affect the safe operation of a motor vehicle.

Yes	No		Yes	No	
☐	☐	Physical impairments	☐	☐	Seizures, fits, blackouts, convulsions, or fainting spells
☐	☐	Orthopedic, musculoskeletal, bone, joint or muscle problems or diseases	☐	☐	Nervous, mental health or psychiatric problems or diseases
☐	☐	Neurological problems or diseases	☐	☐	Visual problems or diseases
☐	☐	Head or spinal injuries	☐	☐	Hearing problems
☐	☐	Cardiovascular problems or diseases	☐	☐	Diabetes

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**

Patient Name: Last: First: M.I.:

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? (mm/dd/yyyy) Date: _____

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:

8. If this patient holds a commercial license, is he/she medically capable of safely operating a commercial motor vehicle? ☐ Yes ☐ No
If 'no', please explain: _____

SECTION A

NEUROLOGICAL, CEREBROVASCULAR, ALTERATION IN CONSCIOUSNESS

A. 1. Has patient experienced a blackout, fainting spell, or syncope? ☐ Yes ☐ No
If 'yes', how often? _____ Date of last occurrence: _____
Was this a one-time episode? ☐ Yes ☐ No 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 seizures <u>not</u> 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

A. 8. Any evidence of organic brain syndrome? ☐ Yes ☐ No

A. 9. Any evidence of cognitive impairment? ☐ Yes ☐ No If 'yes', please explain _____

A. 10. Memory within normal limits? ☐ Yes ☐ No

A. 11. History of frequent or intermittent confusion? ☐ Yes ☐ No

A. 12. 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 must be performed by a neurologist or neurosurgeon and attached to this report.

Patient Name: Last: First: M.I.:

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 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. Does the patient have an implanted cardioverter defibrillator? ☐ Yes ☐ No

B. 8. Was last syncopal episode related to cardiovascular abnormalities or arrhythmias? ☐ Yes ☐ No
If 'yes', please explain: _____

_____

B. 9. Any other findings or cardiovascular, respiratory, or hypertensive problems which could affect patient's ability to safely operate a motor vehicle? ☐ Yes ☐ No
If 'yes', please explain: _____

_____

SECTION C

NERVOUS, MENTAL HEALTH, PSYCHIATRIC, PSYCHOLOGICAL

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

_____

C. 2. Is patient currently under treatment and/or a psychiatrist's care? ☐ Yes ☐ No

C. 3. Is patient compliant with the prescribed treatment and/or medication(s)? ☐ Yes ☐ No

C. 4. Has substance abuse caused psychiatric symptoms? ☐ Yes ☐ No

C. 5. Any other findings or nervous, mental health, psychiatric or psychological problems which could affect patient's ability to safely operate a motor vehicle? ☐ Yes ☐ No
If 'yes', please explain: _____

_____

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

Patient Name: Last: First: M.I.:

SECTION D

ORTHOPEDIC, MUSCULOSKELETAL

D. 1. Explain any limitation of motion: _____

_____

D. 2. Any stiff or flail joints? ☐ Yes ☐ No

D. 3. Any spastic, weak, 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: _____

_____

If 'yes', does the patient have a SPE waiver from FMCSA? ☐ Yes ☐ No ☐ N/A (Non-Commercial License)

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. Is the patient insulin dependent? ☐ Yes ☐ No

E. 4. Has patient ever been in a diabetic coma? ☐ Yes ☐ No If 'yes', date of last coma: _____

E. 5. 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 taking any medications? ☐ 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 _____

National Registry Number _____ **(Required for Medical Providers evaluating Commercial Drivers)**

Physician Address: _____

City: _____ State: _____ Zip: _____

Physician Telephone Number: _____ - _____ - _____

☐ **I have reviewed and evaluated the medical concerns listed on the letter provided to the patient by DDS.**
*** (Please include a copy of the DDS letter with this report)***

_____ _____

Physician Signature **Date**