

**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 or faxed (with coversheet) by the medical provider directly to:

**Department of Driver Services
Medical Review Unit
PO Box 80447
Conyers, Georgia 30013- or-
Fax to :770-918-6266**

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.

<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Physical impairments	<input type="checkbox"/>	<input type="checkbox"/>	Seizures, fits, blackouts, convulsions, or fainting spells
<input type="checkbox"/>	<input type="checkbox"/>	Orthopedic, musculoskeletal, bone, joint or muscle problems or diseases	<input type="checkbox"/>	<input type="checkbox"/>	Nervous, mental health or psychiatric problems or diseases
<input type="checkbox"/>	<input type="checkbox"/>	Neurological problems or diseases	<input type="checkbox"/>	<input type="checkbox"/>	Visual problems or diseases
<input type="checkbox"/>	<input type="checkbox"/>	Head or spinal injuries	<input type="checkbox"/>	<input type="checkbox"/>	Hearing problems
<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular problems or diseases	<input type="checkbox"/>	<input type="checkbox"/>	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

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 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 regimen? 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.

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.

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