MEDICAL FORM

This report must be completed by a licensed physician, physician assistant, or nurse practitioner in addition to any hospital, medical, or VA records that you wish to make part of your medical history with the Department. This examination must have been performed within the twelve (12) months.

DRIVER INFORMATION

Name: Last First Middle Initial Date of Birth

Address: Street City State Zip Driver License #

Mailing Address (if different from above) Phone Number

Describe in detail any medical condition(s) you may have.

Do you take any prescription / non-prescription drugs? Yes____ No____

If yes, list below (attach separate sheet if needed)

Non-Prescription	Dosage	Times Taken	Prescription	Dosage	Times Taken

INFORMATION RELEASE APPROVAL

I hereby authorize a licensed medical provider, _____, to give me any examination he/she deems necessary for the purpose of determining my physical and/or mental fitness to operate a motor vehicle. I also authorize the Department of Safety and Homeland Security to have this information reviewed by a consulting board of unidentified physicians for the purpose of giving the Department a medical evaluation on my case. I understand that the Department is in no way responsible for any expense that arises from this examination.

SIGNATURE OF PATIENT DATE

VISUAL

Without glasses RE 20/ _____ LE 20/ _____ BE 20/ _____
With glasses RE 20/ _____ LE 20/ _____ BE 20/ _____

Field of vision _____ Color vision _____

NEUROLOGICAL / MUSCULOSKELETAL

How long have you treated this Patient?
Years_____ Months_____

Have you examined patient in the last six months?
Yes_____ No_____ Last Examination date: _____

Diagnosis(es):

Are there any complications related to the condition(s)? Yes_____ No_____ If yes, explain.

Within the past year, has the patient been hospitalized for the above condition(s)? Yes_____ No_____
If yes, list dates and status upon discharge.

Does the patient have a history of seizures? Yes_____ No _____ If yes, provide dates of each episode and reason(s).

Indicate the risk of further episodes.

Is the current medication and/or blood serum level within acceptable range?
Yes_____ No_____ Date tested:_____

Blood test results:
_____

Does the patient have any motor deficits / nerve problems that would impair his/her driving ability?
Yes_____ No_____ If yes, describe the condition(s) and the effect on his/her driving.

Does the patient have any other neurological condition(s) that would impair his/her driving ability?
Yes_____ No_____ If yes, describe the condition(s) and the effect on his/her driving.

Does the patient have any chronic condition(s), chronic pain syndrome, fibromyalgia or any other movement disorder? Yes_____ No_____ If yes, specify.

Is the patient prescribed any medication for chronic or long lasting pain? Yes_____ No_____ If yes, list below.

Prescription	Dosage	Times Taken

Does the patient suffer from peripheral neuropathy? Yes_____ No_____ if yes, which extremities are impaired?

Current blood levels of anticonvulsant medication: Test Date: Result of most recent EEG:

_____ _____ _____

Does the neuropathy affect the patient's ability to safely operate a motor vehicle? Yes_____ No_____

Does the patient suffer from muscle spasms? Yes_____ No_____

Does the patient have full Range of Motion of the head and neck? Yes_____ No_____ If no, describe the patient's Range of Motion.

DIABETES

Is this patient a diabetic? Yes_____ No_____ If no, continue to next section.

Diagnosis: _____ Current Treatment: _____

Does this patient take insulin? Yes_____ No_____ If yes, type/dosage: _____

Are there any complications related to this condition? Yes_____ No_____ If yes, explain.

Within the past year, has the patient been hospitalized for the above condition? Yes_____ No_____
If yes, list dates and status upon discharge.

Does the patient's diabetes or any other metabolic conditions affect his/her ability to operate a motor vehicle safely? Yes_____ No_____ If yes, explain.

Do any complications or associated conditions exist? Yes_____ No_____ If yes, explain.

Does this patient have hypoglycemic reactions? Yes_____ No_____ If yes, provide dates and reasons.

Does the patient monitor his/her blood sugar? Yes_____ No_____ If yes, how often?

CARDIOVASCULAR

Does this patient have any type of cardiovascular condition? Yes_____ No_____ If no, continue to next section.

Diagnosis: _____ Current Treatment: _____

Are there any complications related to this condition? Yes_____ No_____ If yes, explain.

Within the past year, has the patient been hospitalized for the above condition? Yes_____ No_____
If yes, list dates and status upon discharge.

Does the patient have an implantable cardioverter defibrillator? Yes_____ No_____ If yes, give date(s).

Has the unit discharged since the implant? Yes_____ No_____ If yes, explain.

Does the patient have a ventricular assist device system? Yes_____ No_____
If yes, when was the device implanted?

Has the patient had any of the following:
Cardiovascular surgery and/or other procedures? Yes_____ No_____ If yes, explain and give dates.

Syncope? Yes_____ No_____ If yes, explain and give dates.

Fatigue with exertion? Yes_____ No_____ Fatigue at rest? Yes_____ No_____

Dyspnea with exertion? Yes_____ No_____ If yes, explain and give dates.

Dyspnea at rest? Yes_____ No_____ If yes, explain and give dates.

Pulmonary symptoms? Yes_____ No_____ If yes, explain and give dates.

PULMONARY
Does this patient have any type of pulmonary condition? Yes_____ No_____ If no, continue to next section.

Diagnosis: _____ Current Treatment: _____

Are there any complications related to this condition? Yes_____ No_____ If yes, explain.

Within the past year, has the patient been hospitalized for the above condition? Yes_____ No_____
If yes, list dates and status upon discharge.

Is oxygen use required? Yes_____ No_____ If yes, describe treatment regimen and provide number of liters.

Dyspnea with exertion? Yes_____ No_____ If yes, explain and give dates.

Dyspnea at rest? Yes_____ No_____ If yes, explain and give dates.

Syncope from cough? Yes_____ No_____ If yes, explain cause and resolution.

Does the patient have a diagnosis of sleep apnea? Yes_____ No_____ If yes, describe treatment regimen.

Does the pulmonary disease prevent activities of daily living? Yes_____ No_____ If yes, identify.

Has the patient been compliant with treatment to the extent that the symptoms are controlled? Yes__No__

Does the pulmonary disease affect the patient's ability to safely operate a motor vehicle? Yes__No__

PSYCHIATRIC / SUBSTANCE ABUSE

Does this patient have any type of psychiatric and/or substance abuse conditions? Yes_____ No_____ If no, continue to next section.

Diagnosis: _____ Current Treatment: _____

Are there any complications related to this condition? Yes_____ No_____ If yes, explain.

Within the past year, has the patient been hospitalized for the above condition? Yes_____ No_____
If yes, list dates and status upon discharge.

Was the hospitalization voluntary? Yes_____ No_____

Does the patient have a condition which results in one or more of the impairments listed below?
Yes__No__ If yes, check all that apply.

___ Poor decision making/ problem solving skills
___ Dementia/confusion
___ Poor impulse control/extremely impulsive
___ Extremely aggressive/destructive behavior
___ Memory loss, Cognitive
___ Hallucinations/delusions
___ Emotional or behavioral instability
___ Poor/impaired judgment

Identify current treatment programs, counseling, and/or medications, etc...

Is the patient currently or has the patient successfully completed a drug/alcohol program?
Yes____ No____ If yes, explain and give dates.

Did the patient experience seizures related to withdrawal? Yes_____ No_____ If yes, explain and give dates.

Has the patient been compliant with substance abuse treatment? Yes_____ No_____

GENERAL RECOMMENDATIONS

This section must be filled out and signed by a licensed physician, physician assistant, or nurse practitioner.

Is the patient's condition(s) stable? Yes_____ No_____ If no, explain.

Is the patient compliant with treatment? Yes_____ No_____ If no, explain.

Does the patient experience side effects of medication, which are likely to impair his/her driving ability? Yes_____ No_____ If yes, explain.

In your medical opinion, is the patient medically safe to operate a non-commercial vehicle?

YES_____ NO_____ AND/OR

In your medical opinion, is the patient medically safe to operate a commercial vehicle such as a tractor trailer, hazardous materials, passenger bus, school bus, etc.?

YES_____ NO_____

In your medical opinion, does the patient need the following: (check all that apply)

___ To be retested by the Department on ___ Knowledge ___Road ___ Both

___ A driver evaluation with a certified independent driver evaluation specialist "CDRS"

___ An adaptive device/equipment required on vehicle

___ A prosthetic / orthotic device ___ Daylight hours only

Additional recommended restrictions:

Current medications (attach separate sheet if needed)

Name	Dosage	Time	Name	Dosage	Time

Physician/ physician assistant/ nurse practitioner (print) Medical Specialty

Medical license number Expiration Date Issuing State Telephone Number

Physician/ physician assistant/ nurse practitioner signature Date

COMPLETE THIS PAGE IF THE PATIENT HAS SUFFERED A MOMENTARY LAPSE OF CONSCIOUSNESS OR CONTROL DUE TO A MEDICAL CONDITION

It has been indicated that _____ suffered a momentary lapse of consciousness or control due to a medical condition. The Department of Safety requires that a person be at least six (6) months lapse free (loss of consciousness or control) to retain his/her driving privileges. Please explain the possible cause of this (loss of consciousness or control) to the best of your ability and the possibility of this condition recurring.

(PLEASE TYPE OR PRINT LEGIBLY)

PHYSICIAN'S EXPLANATION: IN YOUR PROFESSIONAL OPINION, IS THIS PATIENT MEDICALLY ABLE TO DRIVE/OPERATE A MOTORIZED VEHICLE? YES ____ NO ____

_____

_____

_____

_____

_____

_____

_____

_____

_____
SIGNATURE OF PHYSICIAN DATE

PATIENT'S EXPLANATION:

_____

_____

_____

_____

_____

_____

_____

_____

_____
SIGNATURE OF PATIENT DATE

MEDICAL REPORT INSTRUCTIONS

Driver Instructions

1. Review all correspondence from the Tennessee Department of Safety and Homeland Security regarding concerns about your ability to operate a motor vehicle safely.

2. If you received a Notice of Proposed Suspension, you must provide the Department of Safety and Homeland Security the required medical report withing thirty (30) days from the date of the proposed suspension letter to avoid suspension of your driving privileges.

3. Fill out page (1) one of the medical report. You must sign and date the Information Release Approval Section.

4. Take the proposed suspension letter/instruction page and the entire medical report to your medical provider. It is your responsibility to return the completed medical form to the address at the top of the page.

5. When the medical report is received in this office, your medical case will be reviewed and you will be notified in writing if your medical case is approved, disapproved, additional information needed, re-examination required, or any reinstatement fees due.

Medical Provider Instructions

1. The Department of Safety and Homeland Security is seeking information that will allow us to make a decision regarding you patient's ability to safely operate a non-commercial and/or commercial vehicle. The Department is concerned about any condition(s) and/or use of any medication, alcohol, or narcotics which may result in impaired:

** Level of consciousness ** Alertness ** Loss of consciousness ** Reaction time
** Judgment and cognitive function ** Range of Motion ** Vision ** Motor skills

2. Based on the examination that you conduct, please complete the parts of the Medical Form that pertain to your patient's medical condition(s).

3. If your patient was involved in a recent motor vehicle crash, and/or experienced a recent blackout, seizure, insulin reaction, or loss of consciousness or control, the Medical Report must reference these incidents and/or events.

4. Before this medical report can be accepted, the General Recommendations Section must be completed including but not limited to your opinion as to whether the patient is medically capable of operating a motor vehicle, your signature, dated, and any additional documentation required.

5. If you have any questions or need additional information contact the Driver Improvement Section at (615) 251-5235.