

MEDICAL EXAMINATION REPORT

Concerning A Person's Fitness To Drive A Motor Vehicle

Please have your physician complete the medical form found on the back.

A medical is required because of the class of licence you hold, the class of licence you are applying for your age or because you have a medical file with us.

Please ensure that this medical form is returned to Medicals Section, Motor Registration Division at the address shown below or fax to (709) 729-4360.

Thank you in advance for your cooperation. Please note that you are responsible for any costs incurred.

FOR PHYSICIAN USE ONLY

- 1) **Cardiac Condition** -if clinical or objective diagnosis of heart disease circle the N.Y.H.A. as follows:
Class I -no functional impairment, 7 METS or more.
Class II -mild functional limitation, only on major physical effort, METS 5-7.
Class III -moderate impairment, symptoms on light physical activity, METS 2-4.
Class IV -severe impairment, symptoms at rest.
A period based assessment by a cardiologist is required for professional drivers.
- 2) **Aneurysm of the Aorta** -vascular surgeon's assessment may be required. If surgery has been done and recovery has been satisfactory, may be permitted to apply for or retain any class of licence. AAA if \leq 5.5 cm may hold Class 5 or 6, Class 1,2,3 or 4 should not be issued. If AAA is \leq 6.5 cm not eligible for any Class of licence.
- 3) **Epilepsy** -if seizure free for 6 months, compliant with medication and under regular medical care may hold a Class 5. If seizure free on or off medication for 5 years and receives a favourable report from the usual treating physician/Neurologist, may hold any class of licence.
- 4) **Neurological/MSK Disorders** -description of functional limitations required.
- 5) **Diabetes Mellitus** -commercial drivers treated with insulin MUST maintain a log of their blood sugars.
- 6) **Medically diagnosed chronic abuse or dependence on alcohol or other substances** -must have successfully undergone treatment and be monitored for the condition by the same physician for at least 3-6 months.
- 7) **Respiratory Conditions** -if clinical or objective diagnosis of lung disease circle one of the following:
Class I -dyspnea may or may not occur. Its presence is not due to respiratory illness.
Class II -dyspnea when walking briskly on flat surface or on an upward slope.
Class III -dyspnea occurs after climbing stairs or walking on a flat surface at the pace of others of the same age
Class IV -dyspnea occurs after walking 10 minutes on a flat surface, while speaking or undressing, or the person cannot go outside because of shortness of breath.

MEDICAL EXAMINATION REPORT

Name: _____

D.L. # _____

Class: _____

An answer of yes to either question below requires clarification in the comments section below.

<p>1 Cardiac Conditions: (Atherosclerotic or cardiovascular disease, angina, infarct, arrhythmia, surgery, dilation, etc.) Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p style="text-align: center;">If yes, circle functional class (N.Y.H.A.)</p> <table style="margin-left: auto; margin-right: auto;"> <tr> <td style="text-align: center;">I</td> <td style="text-align: center;">II</td> <td style="text-align: center;">III</td> <td style="text-align: center;">IV</td> </tr> </table> <p>2 Vascular Conditions: (Aneurysm, arteriosclerosis, embolism, TIA etc.) Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>3 Aneurysm of the aorta: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Requiring surgery: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>5 cm or more: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>4 Epilepsy: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">Yr. <input type="text"/></td> <td style="width: 25%;">Mo. <input type="text"/></td> <td style="width: 25%;">Day <input type="text"/></td> <td style="width: 25%;">Yr. <input type="text"/></td> <td style="width: 25%;">Mo. <input type="text"/></td> <td style="width: 25%;">Day <input type="text"/></td> </tr> <tr> <td colspan="3">Date of first seizure</td> <td colspan="3">Date of last seizure</td> </tr> </table> <p>Type and dosage of medications _____</p> <p>5 Other neurological disorders: (C.V.A., Parkinson's, T.I.A., Paralysis, Alzheimer's, Narcolepsy, Non-Epileptic Convulsions etc.) Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>6 Diabetes mellitus: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Age at onset _____</p> <p>Oral hypoglycemic: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Insulin: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Under Control: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Type and dosage of diabetic medications _____</p> <p>Severe Hypoglycemic (requiring intervention by an outsider) Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Retinopathy Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>7 Other metabolic or Endocrine disorders: (Hypoglycemia, thyroid, adrenal diseases, etc.) Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>8 Diagnosis of chronic abuse, or dependence on, alcohol or other substances Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Alcoholism: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Subject is sober since..... Yr. <input type="text"/> Mo. <input type="text"/> Day <input type="text"/></p> <p>Other Addiction: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>To your knowledge is that patient taking any drugs that would cause impairment of driving ability. Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If "yes" to the above question, please name drug(s): _____</p>	I	II	III	IV	Yr. <input type="text"/>	Mo. <input type="text"/>	Day <input type="text"/>	Yr. <input type="text"/>	Mo. <input type="text"/>	Day <input type="text"/>	Date of first seizure			Date of last seizure			<p>9 Hearing Loss: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Right ear: <input type="checkbox"/></p> <p>Left ear: <input type="checkbox"/></p> <hr/> <p>10 Respiratory Insufficiency: (Asthma, severe dyspnea, etc.) Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, circle functional class</p> <table style="margin-left: auto; margin-right: auto;"> <tr> <td style="text-align: center;">I</td> <td style="text-align: center;">II</td> <td style="text-align: center;">III</td> <td style="text-align: center;">IV</td> </tr> </table> <p>11 Visual Problems: (glaucoma, cataracts, retinitis, etc.) Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p style="text-align: center;">right left both</p> <p>A) Visual acuity uncorrected</p> <table style="margin-left: auto; margin-right: auto;"> <tr> <td style="text-align: center;">6/</td> <td style="text-align: center;">6/</td> <td style="text-align: center;">6/</td> </tr> <tr> <td style="text-align: center;">6/</td> <td style="text-align: center;">6/</td> <td style="text-align: center;">6/</td> </tr> </table> <p style="text-align: right;">corrected</p> <p>B) Horizontal Visual Field (Confrontation)</p> <p>Right Eye _____ degrees, Left Eye _____ degrees, Both _____ degrees</p> <p>Deficient colour vision: <input type="checkbox"/></p> <p>Deficient binocular vision: <input type="checkbox"/></p> <hr/> <p>12 Muscular-skeletal disorders: (Functional limitation due to arthritis, amputation, ankylosis, deformities, other physical handicaps, motor disorders, etc.) Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>13 Hypertension: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Under control: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Usual B.P. (several readings) _____ / _____</p> <p>Today's B.P. _____ / _____</p> <hr/> <p>14 Other disorders affecting ability to drive: (Vertigo, hypotension, loss of consciousness, fainting, cachexia, senility, side-effects of medication, etc.) Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>15 Mental Illness: (Psychosis, personality disorders, etc.) Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Estimate of Emotional Stability _____</p> <hr/> <p>16 Should the driver be restricted? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Indicate restriction: _____</p> <hr/> <p>17 Is a second medical opinion required? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <hr/> <p>18 If "yes" to above question, will you make arrangements with consultant of choice? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <hr/> <p>19 If you would like the reassessment earlier than that indicated on the medical recall table, the recall should be 6 mos <input type="checkbox"/> 1 yr <input type="checkbox"/> 2 yr <input type="checkbox"/> 3 yr <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/></p> <hr/> <p>20 Is examining physician the family doctor? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <hr/> <p>21 How long has the patient been under your care? _____</p>	I	II	III	IV	6/	6/	6/	6/	6/	6/
I	II	III	IV																								
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6/	6/	6/																									
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COMMENTS (USE A SEPARATE SHEET IF NECESSARY)
 A full description of functional restriction to safe driving is essential:

PHYSICIAN'S CERTIFICATION

To the best of my knowledge this patient _____ is fit / _____ is not fit to safely operate a motor vehicle.

Name and address of physician (in block letters)	Date of Examination:
Signature	Yr. <input type="text"/> Mo. <input type="text"/> Day <input type="text"/>
Telephone (office)	

PRIVACY STATEMENT

Under the authority of the Highway Traffic Act (HTA), personal information will be collected for the purpose of issuing a Newfoundland and Labrador Driver's Licence. Section 6 of the HTA allows Motor Registration Division to disclose an applicant's personal information to other health professionals for the purpose of medical assessments related to driving requirements. Any questions can be directed to the Medical Section at (709) 729-0345

Driver's signature authorising release of information and certifying information provided to physician as correct

Signature _____

OFFICE USE:

