

Confidential Medical Examination Report

Driver/Patient Section			
Patient Last Name	First Name		Middle Initial
Street Address	City	State	ZIP
Customer Identification Number (CIN)	Date of Birth		

Driver Statement of Understanding (Driver signature not required for DMV processing):

- My physician will conduct a medical examination to determine my fitness to operate a motor vehicle safely and responsibly.
- My physician will respond to any additional questions from the Department of Motor Vehicle (DMV).
- I understand that this form will be considered in any decision regarding the issuance of my driver license, pursuant to C.R.S. 42-2-111 & 42-2-112.

Signature of Driver or Patient	Date (MM/DD/YY)
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Driver/Patient (respond to all questions below before seeing your physician)

1. How many driving trips do you make in a typical week? _____
2. Do any of your regular trips involve driving at night? Yes No
3. What is the one-way distance of your furthest regular trip _____ Miles
4. Do any of your regular trips involve speeds ≥ 55 MPH? Yes No
5. Were you pulled over by a police officer in the past year? Yes No
6. Were you involved in a crash as a driver in the past year? Yes No

Physician Section

Instructions: use your best clinical judgment as you **REVIEW AND COMPLETE ALL SECTIONS**. Base severity ratings within each category on your overall assessment of impairment relative to the driving task. **Form must be completed by the Physician (MD or DO) or Physician's Assistant (PA)**. Pursuant to C.R.S. 42-2-112, no civil or criminal action shall be brought against a physician or physician assistant licensed in Colorado for providing a written medical opinion if the physician or physician assistant acts in good faith and without malice.

<p>Examination Date (MM/DD/YY) _____</p> <p>(Form is valid for 180 days from date of exam)</p> <p>Are you the primary care provider for this patient <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, how many times have you seen this patient in the past year? _____</p> <p>If no, are you evaluating this patient for the first time today? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, have you reviewed the patient's medical records? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>To your knowledge, is this patient:</p> <p>Aware of his or her medical diagnosis & status? <input type="checkbox"/> Yes <input type="checkbox"/> Somewhat <input type="checkbox"/> No</p> <p>Aware of functional impairments that may impact driving? <input type="checkbox"/> Yes <input type="checkbox"/> Somewhat <input type="checkbox"/> No</p> <p>Compliant with medications & basic requirements of self-care? <input type="checkbox"/> Yes <input type="checkbox"/> Somewhat <input type="checkbox"/> No</p>	<p>Does this patient have:</p> <p>Cardiovascular Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cardiac Arrhythmia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Failure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>AHA Functional Capacity (circle level if applicable)</p> <p style="text-align: center;">N/A I II III IV</p>
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Need DMV Re-Examination in 1 year? Yes No

Current Medications
 To your knowledge, is this patient subject to any consistent medicine side effects or interactions that may impair driving ability?

Yes
 Possibly
 Not Likely
 No

Based on my observations of this patient and information relayed to me by this individual, I, reasonably and in good faith, believe that _____ is:

Patient Name _____

Recommended license restriction(s):

 Daylight Driving Only
 No Highway/Freeway Driving
 Hand Control
 Mile Radius Only _____
 Restricted MPH _____
 Steering Device
 Specialty Cushion
 Foot Device
 Automatic Transmission Only
 Other _____

Must Choose One

 Fit to operate a motor vehicle safely.
 Fit to operate a motor vehicle safely contingent upon passing a DMV Road Test.
 NOT FIT to operate a motor vehicle safely and responsibly due to significant medical-functional compromise or deficit.
 Fitness to drive determination pending; rehab permit required
 Patient also requires an eye exam

Specialty (Required)	License Number (Required)	Phone Number (Required)	
Street Address		City	State ZIP

Patient Last Name	First Name	Middle Initial
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Cognitive, Cerebrovascular or Neurological Condition is: Stable Progressive N/A

Mental Status _____ (list test and score)

<input type="checkbox"/> Confusion or Disorientation	<input type="checkbox"/> Memory Loss or Forgetfulness	<input type="checkbox"/> Inattention or Distractibility
<input type="checkbox"/> Impaired Judgment	<input type="checkbox"/> Visual-Spatial Deficit	<input type="checkbox"/> Slowed Processing Speed
<input type="checkbox"/> Cognitive Impairment	<input type="checkbox"/> Cerebrovascular Disease	<input type="checkbox"/> Neurological Condition
<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Cerebral Infarction or Stroke	<input type="checkbox"/> Brain Injury (open or closed)
<input type="checkbox"/> Vascular Dementia	<input type="checkbox"/> Hemorrhage or Aneurysm	<input type="checkbox"/> Tumor or Malformation
<input type="checkbox"/> Frontotemporal or Pick's	<input type="checkbox"/> Transient Ischemic Attack	<input type="checkbox"/> Parkinson's Disease
<input type="checkbox"/> Dementia (other or unknown)	<input type="checkbox"/> Carotid Occlusion or Hypoxia	<input type="checkbox"/> Multiple Sclerosis

Combined Impairment for Driving → Unimpaired (Likely fit to Drive) Very Mild (Likely fit to Drive) Mild (Questionable Fitness) Moderate (Likely Unfit to Drive) Severe (Unfit to Drive)

Check (X) Highest Level for Section →

Consciousness, Metabolic or Respiratory Condition is: Stable Progressive N/A

*Date of last event with impaired consciousness (MM/DD/YYYY): _____

<input type="checkbox"/> Disorder of Consciousness or Alertness*	<input type="checkbox"/> Sleep Apnea or Narcolepsy	<input type="checkbox"/> Medication Effect
<input type="checkbox"/> Blackout or Syncope*	<input type="checkbox"/> Epilepsy or Seizure Disorder	<input type="checkbox"/> Dizziness or Postural Hypotension
<input type="checkbox"/> Chronic Sleep Deprivation		<input type="checkbox"/> Respiratory Condition
<input type="checkbox"/> Metabolic Condition		<input type="checkbox"/> Asthma or shortness of Breath
<input type="checkbox"/> Diabetes (Type 1 or 2)		<input type="checkbox"/> COPD
<input type="checkbox"/> Thyroid Condition (Hypo or Hyper)		<input type="checkbox"/> Oxygen Dependent
<input type="checkbox"/> Morbid Obesity or Fluid retention		

Combined Impairment for Driving → Unimpaired (Likely fit to Drive) Very Mild (Likely fit to Drive) Mild (Questionable Fitness) Moderate (Likely Unfit to Drive) Severe (Unfit to Drive)

Check (X) Highest Level for Section →

Musculoskeletal, Movement or Neuromuscular Condition is: Stable Progressive N/A

Check All That Apply:

<input type="checkbox"/> Arthritis (Osteo or Rheumatoid)	<input type="checkbox"/> Frailty or General Weakness	<input type="checkbox"/> Motor Neuron Disease	<input type="checkbox"/> Muscular Dystrophy
<input type="checkbox"/> Uses Cane or Walker	<input type="checkbox"/> Paralysis - Arm	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Parkinson's Disease
<input type="checkbox"/> Wheelchair Dependent	<input type="checkbox"/> Paralysis - Leg	<input type="checkbox"/> Restricted or Weakness - Arm	<input type="checkbox"/> Loss of Limb
<input type="checkbox"/> Difficulty Transferring	<input type="checkbox"/> Prosthesis or Brace - Arm	<input type="checkbox"/> Restricted or Weakness - Leg	<input type="checkbox"/> History of Falls
<input type="checkbox"/> Problems with Balance	<input type="checkbox"/> Prosthesis or Brace - Leg	<input type="checkbox"/> Restricted Neck Range of Motion	<input type="checkbox"/> Other _____
		<input type="checkbox"/> Orthopedic or Movement	

Combined Impairment for Driving → Unimpaired (Likely fit to Drive) Very Mild (Likely fit to Drive) Mild (Questionable Fitness) Moderate (Likely Unfit to Drive) Severe (Unfit to Drive)

Check (X) Highest Level for Section →

Psychiatric, Emotional or Addiction Condition is: Stable Progressive N/A

<input type="checkbox"/> Depression	<input type="checkbox"/> Bipolar Mood Disorder	<input type="checkbox"/> Psychosis or Schizophrenia	<input type="checkbox"/> Alcohol Abuse or Addiction	<input type="checkbox"/> Drug Abuse or Addiction
<input type="checkbox"/> Suicidal or Homicidal	<input type="checkbox"/> Anxiety or Post-Traumatic Stress	<input type="checkbox"/> Chronic Pain (causing distress)	<input type="checkbox"/> Other _____	

Combined Impairment for Driving → Unimpaired (Likely fit to Drive) Very Mild (Likely fit to Drive) Mild (Questionable Fitness) Moderate (Likely Unfit to Drive) Severe (Unfit to Drive)

Check (X) Highest Level for Section →

Physician Name (Printed)	Signature (Required)	Date (MM/DD/YY)
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