PHYSICIAN'S STATEMENT OF EXAMINATION

Michigan Department of State
Driver Assessment and Appeal Division
P.O. Box 30196
Lansing, Michigan 48909-7696

Phone: (517) 335-7051 **Fax: (517) 335-2189**

INSTRUCTIONS FOR DRIVER/APPLICANT:
The Department of State has received information that you may be afflicted with a physical and/or mental condition that may prevent you from operating a motor vehicle safely. Please have your regular physician complete this statement and return it to the address above. It cannot be processed at a local branch office. Failure to have this form completed and returned may result in your license being withheld until we have received and evaluated this statement.

RELEASE OF INFORMATION

(Application cannot be processed without signature)

To be completed by applicant or applicant's representative. Please Print.

Name (First, Middle, Last)	Date of Birth	Driver License Number	
Street Address		Daytime Telephone	
City		State	Zip
I hereby authorize and request that information regarding my medical condition be released to the Michigan Department of State.			
Applicant's Signature ______		Today's Date ______	

INSTRUCTIONS FOR PHYSICIAN: (Physician, you must complete the Physician's Certification on the last page.)
Please fill out all section(s) indicated or that in your professional opinion, are pertinent to this applicant to help in our assessment.
The Department of State is asking for assistance in the determination of this patient's physical and mental condition as it may relate to their continued safe operation of a motor vehicle. Information may be mailed directly to the Department at the address shown at the top of this form. PLEASE TYPE OR PRINT YOUR ANSWERS.

[ ] (Section A) NEUROLOGICAL OR NEUROMUSCULAR DISEASES (Page 2)
[ ] (Section B) OTHER MEDICAL DISORDERS, GENERAL MEDICAL CONDITIONS (Pages 3-4)
[ ] (Section C) DRUGS AND ALCOHOL (Page 4)
[ ] (Section D) PSYCHOLOGICAL EVALUATION (Page 5)
[XX] (Section E) COMMENTS SECTION (Must Be Completed For All Applicants) (Page 6)

Do Not Write below this line

FOR DRIVER ASSESSMENT USE ONLY

[ ] FAVORABLE ______ [ ] SET UP ______
[ ] RESTRICTION ______
[ ] MUST PASS ______ TEST
[ ] UNFAVORABLE ______
[ ] QUESTIONABLE ______
[ ] REFER FOR REEXAMINATION
[ ] NEED ADDITIONAL INFORMATION ______
[ ] MEDICAL [ ] VISION [ ] SKILLS TESTING

REVIEWED BY ______ ***DATE*** ______

 Authority granted under Act. No. 300 of the Public Acts of 1949, as amended

SECTION A NEUROLOGICAL AND NEUROMUSCULAR DISEASES

I. Disease Causing Loss or Impairment of Consciousness or Confusion:

[ ] Epilepsy - Type: ____________________

[ ] Narcolepsy

[ ] Alcoholism (complete Drugs and Alcohol Section on page 4)

[ ] Cerebral Vascular Disease/Insufficiency (complete Atherosclerosis/Heart Disease Section on pages 3-4)

[ ] Vasovagal Syncope ____________________

[ ] Other (open & closed head injuries, craniotomies, etc.) Please explain: ____________________

____

Related Information:

A. Age of patient at onset of illness: ________ Date of last seizure or episode: _____/_____/_____

B. Frequency of seizure or episode: ____________________

(i) Has patient reported a seizure or episode within the last 6 months? Yes [ ] No [ ]

(ii) Has patient reported a seizure or episode within the last 12 months? Yes [ ] No [ ]

(iii) Did patient experience a loss or impairment of level of consciousness? Yes [ ] No [ ]

C. Current medication and dosage: Start Date__________ Medication__________ Dosage __________ Start Date __________ Medication __________ Dosage__________

D. Is there *reasonable* medical certainty that the last seizure or episode resulted from a medically supervised change in medication or dosage? Yes [ ] No [ ] If yes, please explain: ____________________

____

E. Has patient had any adverse reaction to treatment or medication? Yes [ ] No [ ] If yes, please explain:

____

II. Other Limiting or Progressive Neurological or Neuromuscular Diseases:

(Cerebral Palsy, Paraplegia, Muscular Dystrophy, Parkinsonism, Multiple Sclerosis, etc.)

A. Specific diagnosis: ____________________ Age of patient at onset of illness: __________

B. Please describe the patient's neuromuscular condition, including changes that are likely in the future: __________

____

C. Current medication and dosage: Start Date __________ Medication __________ Dosage__________ Start Date __________ Medication __________ Dosage __________

D. Is patient's disease/condition adequately controlled with medication? Yes [ ] No [ ]

E. Do you believe the patient is capable of safely operating a motor vehicle based on the current medical condition, including medications? Yes [ ] No [ ] If no, please explain: ____________________

____

III. Diseases Affecting Cognition:

[ ] Dementia or Senility [ ] Poor Memory [ ] Other

[ ] Impairment of Judgment [ ] Mental Retardation

A. Specific diagnosis: ____________________

B. Please describe the severity of the illness, treatment and prognosis: ____________________

____

C. Current medication and dosage: Start Date __________ Medication__________ Dosage __________

D. Do you believe the patient is capable of safely operating a motor vehicle based on the current medical condition, including medications? Yes [ ] No [ ] Please explain: ____________________

SECTION B OTHER MEDICAL DISORDERS, GENERAL MEDICAL CONDITIONS

I. Diabetes and Other Metabolic Disorders

A. Type #l [ ] Type #2 [ ] Age at onset: ____________

B. Insulin Injections? Yes [ ] No [ ] Start Date ____________ Strength ________ Frequency ________

C. Patient follows diet instructions? Yes [ ] No [ ]

D. Patient is responsible in the management of the disease? Yes [ ] No [ ] Comments: ____________

____

E. Reaction episodes - Those causing loss or impairment of level of consciousness:

Hypoglycemic	Yes [ ]	No [ ]	Frequency ____________
Hyperglycemic	Yes [ ]	No [ ]	Frequency ____________
Renal Disease	Yes [ ]	No [ ]	BUN ____________
			Creatinine ____________

F. Was the episode unusual in the nature for this driver/patient? Yes [ ] No [ ] Please explain: ____________

____

Date of last episode: ____________ Symptoms:

Impairment of level of consciousness:	Yes [ ]	No [ ]
Loss of motor skills:	Yes [ ]	No [ ]
Loss of judgment:	Yes [ ]	No [ ]
Difficulty recalling the episode:	Yes [ ]	No [ ]

Please explain any yes responses: ____________

____

G. Patient's condition stabilized? Yes [ ] No [ ]

H. Is there reasonable medical certainty that the last episode resulted from medically supervised change in medication or dosage? Yes [ ] No [ ] Please explain: ____________

____

I. Date of last blood glucose test: _____/_____/_____ Blood glucose level: ________ Frequency of test: ________

J. Vision problems: Yes [ ] No [ ] Please describe: ____________

____

II. Atherosclerosis/Heart Disease

A. Diagnosis: ____________

B. Peripheral vascular disease? Yes [ ] No [ ] Location of disease, i.e., arms, legs, etc., and extent of disability: ____________

____

C. Cerebral vascular disease: Yes [ ] No [ ]

D. Coronary vascular disease: Yes [ ] No [ ]

Angina:	Yes [ ]	No [ ]	Frequency ________ Date of onset _____/_____/_____
During Driving	Yes [ ]	No [ ]	
Dyspnea	Yes [ ]	No [ ]	
Syncope:	Yes [ ]	No [ ]	Near Syncope or Confusion: Yes [ ] No [ ]
			Frequency ________ Date of last Syncope ________
Arrhythmia:	Yes [ ]	No [ ]	Frequency ________ Type ________
Infarction:	Yes [ ]	No [ ]	Dates: ____________
Congestive Failure:	Yes [ ]	No [ ]	Ever: Yes [ ] No [ ]
Pacemaker:	Yes [ ]	No [ ]	
Hypertension:	Yes [ ]	No [ ]	Blood Pressure: ____________
			Heart Rate: ____________

E. Current medication and dosage: Start Date ________ Medication ____________
Dosage ________ Start Date ________ Medication ________ Dosage ________

OTHER MEDICAL DISORDERS, GENERAL MEDICAL CONDITIONS (Continued)

F. Has patient had any adverse reaction to medication or treatment for the condition? Yes [ ] No [ ]

If yes, please explain: ______________________________

G. Has patient reached maximum recovery period? Yes [ ] No [ ] If no, expected date:_____/_____/_____

If yes, please explain: ______________________________

Please Circle:

Functional Classification I II III IV Therapeutic Classification A B C D E

H. Is the above condition medically treatable? Yes [ ] No [ ] Please elaborate: ______________________________

____

Please describe how this condition may affect the patient's ability to operate a motor vehicle safely: ______________________________

____

III. General Medical Conditions (Not discussed in other sections)

A. Diagnosis: ______________________________

B. Current Medication and Dosage: Start Date__________ Medication__________

Dosage__________ Start Date__________ Medication__________ Dosage__________

C. Has patient had any adverse or other reaction to treatment or medication? Yes [ ] No [ ]

D. Do you recommend driving restrictions? Yes [ ] No [ ] If yes, please explain: ______________________________

____

SECTION C DRUGS AND ALCOHOL

A. Does the patient have any clinical evidence or do you have personal knowledge of patient's addiction or habituation to drugs, alcohol or tranquilizers? Yes [ ] No [ ] If yes, indicate drug and duration of addiction: ______________________________

____

B. Has patient attended residential treatment or hospitalization for condition? Yes [ ] No [ ] If yes, indicate dates of treatment or hospitalization: ______________________________

C. Is patient currently under therapy? Yes [ ] No [ ] If yes, where? ______________________________

Duration and frequency of therapy: ______________________________

D. Is there evidence of physical complications from alcohol or drug abuse? Yes [ ] No [ ] If yes, please explain:

____

E. Has patient been advised to abstain from addicted substance? Yes [ ] No [ ]

F. Has patient followed your recommendations for treatment or therapy? Yes [ ] No [ ]

G. Has patient been prescribed antabuse? Yes [ ] No [ ]

H. Is patient's antabuse monitored? Yes [ ] No [ ] If yes, frequency of monitoring and by whom: ______________________________

____

____

I. Has period of abstinence or control been established? Yes [ ] No [ ] If yes, date of last consumption/use: ______________________________

____

J. What is your professional prognosis for this patient's condition? ______________________________

____

SECTION D PSYCHOLOGICAL EVALUATION

A. Diagnosis of psychiatric illness: ______________________________

B. Approximate date of illness onset: ____________________________

C. Which of the following symptoms are present? (Please check)

[ ] Anxiety	[ ] Paranoid Ideation	[ ] Hallucinations
[ ] Depression	[ ] Suicidal Impulses	[ ] Impairment of Judgment
[ ] Euphoria	[ ] Homicidal Impulses	[ ] Poor Memory
[ ] Poorly Controlled Anger	[ ] Insomnia	[ ] Mental Retardation
[ ] Bizarre Behavior	[ ] Delusions	
[ ] Dementia or Senility	[ ] Other________________________	

Please expand on any of the above, including approximate duration of illness, severity of illness, treatment and prognosis: ____

____

D. Current medication and dosage: Start Date ___________________ Medication ________________________________
Dosage_____________________ Start Date___________________Medication _______________ Dosage_______________

E. Has patient had any adverse reaction to medication, treatment or therapy? Yes [ ] No [ ] If yes, please explain:

____

____

F. Does medication(s) make patient drowsy? Yes [ ] No [ ]

G. Is patient capable of operating a motor vehicle safely while taking the above prescribed medications(s)? Yes [ ] No [ ]
Please explain: ____

H. Has patient been hospitalized for the disorder? Yes [ ] No [ ] If yes, please indicate when, where and for how long:

____

Frequency of therapy: ____

I. Does patient follow your medical and psychiatric recommendations? Yes [ ] No [ ] Please elaborate: ______________

____

J. Do you believe this patient is capable of safely operating a motor vehicle based on patients current medical condition, including medications? Yes [ ] No [ ] Please explain: ______________________________________

____

K. Do you recommend any driving restrictions based on medication or current medical condition of this patient?
Yes [ ] No [ ] If yes, please explain: ____

____

L. Other comments or recommended driving restrictions based on psychological condition of this patient: _________________

____

SECTION E COMMENTS SECTION

General Patient Information and Medical Related Driving Recommendations:

1. How long has patient been under your treatment?________________________________
2. Has patient followed your medical recommendations? Yes [ ] No [ ]
3. Date of most recent medical examination: ______/______/______
4. Does patient take medication as prescribed? Yes [ ] No [ ]
5. Please explain any **no** answers to the above questions:________________________________

6. Was patient referred to you by another doctor? Yes [ ] No [ ] If yes, please indicate name and address of referring doctor:________________________________
7. Have you referred patient to another medical specialist for diagnosis or treatment? Yes [ ] No [ ] If yes, please indicate name and address of medical specialist patient was referred:________________________________

   What were the results of this consultation?________________________________

8. Any adverse reactions to medication, treatment or therapy? Yes [ ] No [ ] Please explain: ________________________________

   a. Does medication make patient drowsy? Yes [ ] No [ ]

   b. Is patient capable of safely operating a motor vehicle while taking the above medication(s)? Yes [ ] No [ ]
   Please explain: ________________________________

9. Has the patient ever had occupational or physical therapy for the condition in question? Yes [ ] No [ ]
10. Do you recommend that the Department request a statement of your patient's psychological condition? Yes [ ] No [ ]
11. Do you recommend that the Department request a statement of your patient's visual acuity? Yes [ ] No [ ]
12. Should the Department require periodic medical evaluation to monitor changes in patient's condition that may affect driving ability? Yes [ ] No [ ] If yes, how often?________________________________
13. Do you recommend any driving restrictions (times, trip lengths, trip radius, adaptive equipment, etc.)? Yes [ ] No [ ]
    If yes, please specify: ________________________________
14. Do you recommend the Department conduct an on-the-road driving performance evaluation for this driver at this time?
    Yes [ ] No [ ] Periodically? Yes [ ] No [ ] How often?________________________________
15. Please include any additional information you feel will help in assessing your patient's ability to safely operate a motor vehicle:________________________________

(Please complete entire certification.)

PHYSICIAN'S CERTIFICATION

As of this date, I certify that the statements contained in this statement of examination are true to the best of my knowledge and belief.

Name (Print or Type) ________________________ M.D or D.O Telephone No.( ) ____________

Address ________________________ City______________ State_____ Zip________

Professional License No. ________________ Type of Practice or Medical Specialty ________________

Physician's Signature: X ________________________________ **Date** ____________