

PHYSICIAN'S STATEMENT OF EXAMINATION

Michigan Department of State

P.O. Box 30810, Lansing, Michigan 48909-9832

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www.Michigan.gov/sos



Reason for Referral (to be completed by Department of State personnel or referring health care provider)

Reason for Referral: _____

Driver indicated a loss or impairment of consciousness within last: 6 months 12 months or more Date: ___/___/___

Driver may have a medical condition that could affect safe driving within the last: 6 months 12 months or more

Name and Title of Referrer: _____

Signature of Referrer: _____ Telephone _____

Instructions for Driver/Applicant

1. Complete Sections 1 through 4 with all of the information that applies to you. Please print or type.
2. Have your physician complete the other sections. The information in this form must be based upon an examination within three months from the date of your physician's certification.
3. Either you or your physician may return the completed form by fax, mail, or E-mail (see contact information above). This form must be received by the department within three months after your physician signs it.

SECTION 1: Driver/Applicant Information

Name (First, Middle, Last)	Date of Birth	Driver's License Number	
Street Address		Telephone Number 8 a.m. – 5 p.m.	
City	State	ZIP	Today's Date

SECTION 2: History

Do you have, or have you had, any of the following conditions? Check all that apply:

- | | |
|---|---|
| <input type="checkbox"/> Cardiovascular problems or disease | <input type="checkbox"/> Orthopedic, musculoskeletal, bone, joint or muscle problems or disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Physical impairments |
| <input type="checkbox"/> Head or spinal injuries | <input type="checkbox"/> Seizures, blackouts, convulsions, or fainting |
| <input type="checkbox"/> Mental or psychiatric problem or disease | <input type="checkbox"/> Sleep disorders |
| <input type="checkbox"/> Neurological problems or disease | <input type="checkbox"/> Substance Use/Abuse |

Please explain any conditions checked above: _____

Please list any other health problems: _____

SECTION 3: General Questions for Driver/Applicant

1. How many traffic accidents have you been involved in while driving in the past 5 years? _____ None
2. Were you injured in any traffic accidents? Yes No
If yes, please describe your injuries: _____
Was treatment given? Yes No If yes, where was treatment given? _____
3. Describe any loss of consciousness or any impairment of consciousness in the past 5 years: _____
_____ None
Did you tell your doctor about the event(s)? Yes No
If yes, what was the diagnosis for the event(s)? _____
4. Have you ever become lost when driving in familiar areas? Yes No
5. Has any family member or friend made a suggestion that you not drive or limit your driving? Yes No
6. Have you ever been told by a doctor to limit or stop driving? Yes No
7. How many times in the past 5 years have you had contact with police as a result of a traffic stop or accident?
_____ None
8. Do you require a passenger to assist you when driving? Yes No
9. Please list all medications you are currently prescribed and/or taking: _____

10. How many alcoholic drinks do you consume per day? _____ Per week? _____ Per month? _____
11. Have you had treatment or a recommendation for treatment for any of the following? :
Alcohol Use Yes No Illicit Drug Use Yes No Prescription Drug Use Yes No
12. Do you wear or use any of the following corrective lenses? Check all that apply:
 Glasses Contacts Telescopic Lens Device Other: _____
13. Do you have any progressive or degenerative diseases of the eye? Check all that apply: Retinitis Pigmentosis
 Cataracts Glaucoma Macular Degeneration Diabetic Retinopathy Other: _____
14. How often do you drive at night? Regularly Sometimes Never
15. How often do you drive on the freeway? Regularly Sometimes Never
16. How many miles do you drive per day? _____ Per week? _____ Per month? _____
17. How often do you wear your seatbelt? Always Sometimes Never

SECTION 4: Driver/Applicant Certification

I hereby authorize the release of information to the Department of State only for the purpose of assisting in evaluating my ability to safely operate a motor vehicle. I am aware that the Department of State may contact my physician for clarification or follow-up. I certify that my responses contained in this document are true and accurate to the best of my knowledge and belief.

Driver/Applicant's Signature: _____

If you assisted the driver/applicant with the completion of this form, please complete the following information.

Name	Telephone Number	Relationship to Driver/Applicant	
Address	City	State	Zip

I am completing Sections 1 through 4 of this form at the request of the driver/applicant.

Signature: _____ Date: _____

PHYSICIAN'S STATEMENT OF EXAMINATION

Instructions for Physician

1. Review statements on pages one and two. You may contact the Traffic Safety Division at (517) 335-7051 for additional information regarding the reason for referral.
2. Complete Sections 5 through 7 based upon an examination within three months from the date of your certification. Please print or type your answers and attach additional pages if necessary.
3. Either you or the patient may return this form to the department by fax, mail, or E-mail (see top of page 1 for contact information). It must be received within three months after your certification.

SECTION 5: General Questions for Physician

1. How long has the patient been under your care? _____ Date of most recent medical exam _____

2. Do you have concerns about the patient's physical or mental capability to safely operate a motor vehicle? Yes No

Please explain: _____

3. If applicable, please check the following cognitive tests that were administered to the patient and list any concerns:

	Intact	Impaired		Intact	Impaired
<input type="checkbox"/> Mini Mental State Exam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Clock Drawing	<input type="checkbox"/>	<input type="checkbox"/>			

Concerns: _____

4. If applicable, please check the following functional tests that were administered to the patient and list any concerns:

	Intact	Impaired		Intact	Impaired
<input type="checkbox"/> Rapid Pace Walk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Range of Motion – Head and Neck Rotation Test	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Manual Test of Motor Strength	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

Concerns: _____

5. Do you recommend the department request an assessment of the patient's?

Visual Condition	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Psychiatric/Psychological Condition	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Substance Use	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If yes, please explain: _____

6. What types of driving restrictions, if any, do you recommend the Department of State should consider based upon the patient's medical condition(s) (e.g., adaptive equipment, daylight driving only, trip lengths, trip radius, etc.)?

Please specify: _____

7. Should the department require periodic medical evaluations to monitor changes in the patient's condition? Yes No

If yes, specify condition and evaluation frequency: _____

8. Do you recommend the department conduct an on-the-road driving evaluation? Yes No

SECTION 6: Current Diagnoses, Medications, Treatment and Prognosis

Complete the following diagnoses sections, in the order of importance, for the medical condition(s) that may affect the patient's ability to safely operate a motor vehicle. Attach additional pages if necessary.

PRIMARY DIAGNOSIS (most likely to impair driving)				
Diagnosis:	The patient's condition is (check all that apply): <input type="checkbox"/> Episodic <input type="checkbox"/> Chronic <input type="checkbox"/> Progressive	Prescribed Medication	Dosage	Start Date
Symptoms:				
Age at onset:				
Prognosis:	<input type="checkbox"/> Guarded <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Excellent			
Supporting facts for prognosis:				
Treatment or therapy plan:				
Does the patient report the condition is adequately controlled with medication, treatment or therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A				
Comments:				
Is another medical specialist involved in treatment of this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, name and specialty:				
Has the patient reported a loss of, or impairment of consciousness? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, please describe:				
Date of last episode: _____ Frequency: _____				
If the patient experienced an episode or medical event, is there reasonable medical evidence it was due to a medically supervised change in medication or dosage? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A				
If yes, please explain:				
Comments:				

SECONDARY DIAGNOSIS (second most likely to impair driving)				
Diagnosis:	The patient's condition is (check all that apply): <input type="checkbox"/> Episodic <input type="checkbox"/> Chronic <input type="checkbox"/> Progressive	Prescribed Medication	Dosage	Start Date
Symptoms:				
Age at onset:				
Prognosis:	<input type="checkbox"/> Guarded <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Excellent			
Supporting facts for prognosis:				
Treatment or therapy plan:				
Does the patient report the condition is adequately controlled with medication, treatment or therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A				
Comments:				
Is another medical specialist involved in treatment of this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, name and specialty:				
Has the patient reported a loss of, or impairment of consciousness? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, please describe:				
Date of last episode: _____ Frequency: _____				
If the patient experienced an episode or medical event, is there reasonable medical evidence it was due to a medically supervised change in medication or dosage? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A				
If yes, please explain:				
Comments:				

TERTIARY DIAGNOSIS (Third most likely to impair driving)

Diagnosis:	The patient's condition is (check all that apply):	Prescribed Medication	Dosage	Start Date
Symptoms:	<input type="checkbox"/> Episodic <input type="checkbox"/> Chronic			
Age at onset:	<input type="checkbox"/> Progressive			
Prognosis: <input type="checkbox"/> Guarded <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Excellent				
Supporting facts for prognosis:				
Treatment or therapy plan:				
Does the patient report the condition is adequately controlled with medication, treatment or therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A				
Comments:				
Is another medical specialist involved in treatment of this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, name and specialty:				
Has the patient reported a loss of, or impairment of consciousness? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, please describe:				
Date of last episode: Frequency:				
If the patient experienced an episode or medical event, is there reasonable medical evidence it was due to a medically supervised change in medication or dosage? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A				
If yes, please explain:				
Comments:				

SECTION 7: Physician's Certification

Name (First, Middle, Last)	M.D. or D.O.	Professional License Number	
Address	City	State	ZIP
Telephone Number	Type of Practice or Medical Specialty		

As of this date, I certify that I have reviewed Sections 1 through 4 and completed Sections 5 through 7 and that this Physician's Statement of Examination is true to the best of my knowledge and belief based on information obtained from the patient, the patient's known medical history, and a patient examination. I understand that the decision to grant, suspend, or reinstate an individual's driving privileges rests solely with the Department of State, which may consider other facts or conditions when making this decision.

Physician's Signature: _____ **Date:** _____
(Required)

Sign below if this form was completed by a psychologist, physician's assistant, or nurse practitioner.
NOTE: Nurse practitioner signature must include supervising physician's countersignature.

PSY/PA/NP Signature: _____ **Date:** _____

For Driver Assessment Use Only

- FAVORABLE _____ COME-UP DATE _____
- RESTRICTION _____
- MUST PASS _____
- UNFAVORABLE _____
- QUESTIONABLE _____
- REFER FOR REEXAMINATION _____
- NEED ADDITIONAL INFORMATION _____
- MEDICAL VISION SKILLS TESTING SUBSTANCE USE DISORDERS EVALUATION

REVIEWED BY: _____ DATE: _____