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; E-mail: medicalforms@Michigan.gov
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:

☐ Cardiovascular problems or disease
☐ Diabetes
☐ Head or spinal injuries
☐ Mental or psychiatric problem or disease
☐ Neurological problems or disease
☐ Orthopedic, musculoskeletal, bone, joint or muscle problems or disease
☐ Physical impairments
☐ Seizures, blackouts, convulsions, or fainting
☐ Sleep disorders
☐ 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 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 Driver Assessment and Appeal Division at (517) 335-7051 for additional information regarding the reason for referral.
2. Complete Sections 5 through 8 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
☐ Mini Mental State Exam	☐	☐	☐ Other: ____________________	☐	☐
☐ Clock Drawing	☐	☐			

   Concerns: ____

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

	Intact	Impaired		Intact	Impaired
☐ Rapid Pace Walk	☐	☐	☐ Range of Motion – Head and Neck Rotation Test	☐	☐
☐ Manual Test of Motor Strength	☐	☐	☐ Other: ______________________	☐	☐

   Concerns: ____

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

Visual Condition	☐ Yes ☐ No	Psychiatric/Psychological Condition	☐ Yes ☐ No
Substance Use	☐ Yes ☐ No	Other ________________________	☐ Yes ☐ 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: Symptoms: Age at onset:	The patient's condition is (check all that apply): ☐ Episodic ☐ Chronic ☐ Progressive	**Prescribed Medication**	**Dosage**	**Start Date**

Prognosis: ☐ Guarded ☐ Poor ☐ Fair ☐ Good ☐ Excellent
Supporting facts for prognosis:

Treatment or therapy plan:

Does the patient report the condition is adequately controlled with medication, treatment or therapy? ☐ Yes ☐ No ☐ N/A
Comments:

Is another medical specialist involved in treatment of this condition? ☐ Yes ☐ No
If yes, name and specialty:

Has the patient reported a loss of, or impairment of consciousness? ☐ Yes ☐ 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? ☐ Yes ☐ No ☐ N/A
If yes, please explain:

Comments:

SECONDARY DIAGNOSIS (second most likely to impair driving)

Diagnosis: Symptoms: Age at onset:	The patient's condition is (check all that apply): ☐ Episodic ☐ Chronic ☐ Progressive	**Prescribed Medication**	**Dosage**	**Start Date**

Prognosis: ☐ Guarded ☐ Poor ☐ Fair ☐ Good ☐ Excellent
Supporting facts for prognosis:

Treatment or therapy plan:

Does the patient report the condition is adequately controlled with medication, treatment or therapy? ☐ Yes ☐ No ☐ N/A
Comments:

Is another medical specialist involved in treatment of this condition? ☐ Yes ☐ No
If yes, name and specialty:

Has the patient reported a loss of, or impairment of consciousness? ☐ Yes ☐ 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? ☐ Yes ☐ No ☐ N/A
If yes, please explain:

Comments:

TERTIARY DIAGNOSIS (Third most likely to impair driving)

Diagnosis: Symptoms: Age at onset:	The patient's condition is (check all that apply): ☐ Episodic ☐ Chronic ☐ Progressive	Prescribed Medication	Dosage	Start Date

Prognosis: ☐ Guarded ☐ Poor ☐ Fair ☐ Good ☐ Excellent
Supporting facts for prognosis:

Treatment or therapy plan:

Does the patient report the condition is adequately controlled with medication, treatment or therapy? ☐ Yes ☐ No ☐ N/A
Comments:

Is another medical specialist involved in treatment of this condition? ☐ Yes ☐ No
If yes, name and specialty:

Has the patient reported a loss of, or impairment of consciousness? ☐ Yes ☐ 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? ☐ Yes ☐ No ☐ 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 thru 4 and completed Sections 5 thru 8 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.

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: ________