STATE OF NORTH CAROLINA
# DEPARTMENT OF TRANSPORTATION

JOSH STEIN
GOVERNOR

J.R. "JOEY" HOPKINS
SECRETARY

## North Carolina Division of Motor Vehicles
## Consent/Information Form

Name: _____

Address: _____

City: _____

Customer No: _____

Dear Customer:

It has become necessary for the Medical Review Unit of the Division of Motor Vehicles to review your ability to continue to safely operate a motor vehicle.

The enclosed Medical Report Form should be completed by your physician and returned for evaluation. It is important that the Medical Report Form be completed and returned to the Medical Review Section to avoid cancellation of your driving privilege. The form must be signed and dated by you and your medical provider.

Please give this matter your immediate attention in order to expedite the processing of your medical evaluation. If you have questions, you may contact us at (919) 861-3809 between 8:00 a.m. and 5:00 p.m. Monday through Friday.

If you wish to be considered for removal from the Medical Review Unit, please submit a written request containing your name, date of birth, and driver license number to Medical Review Program, 3112 Mail Service Center, Raleigh, NC 27697-3112. We will provide a written response to your request within thirty days.

Sincerely,
Director of Customer Compliance Services
Division of Motor Vehicles
Enclosures


Mailing Address:

NC DIVISION OF MOTOR VEHICLES
CUSTOMER COMPLIANCE SERVICES
MEDICAL REVIEW UNIT
3112 MAIL SERVICE CENTER
RALEIGH, NC 27697-3112

Contact Information:

Telephone: (919) 861-3809
Fax Numbers: (919) 733-9569
(919) 861-3284
(919) 861-3836
Website: www.ncdot.gov

Location:

DMV HEADQUARTERS BUILDING
1515 N CHURCH ST
ROCKY MOUNT, NC 27804

STATE OF NORTH CAROLINA
# DEPARTMENT OF TRANSPORTATION

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** IMPORTANT**

Instructions for Completing Medical Report

1. In order to be reviewed, the form must be signed and dated by youand your medical provider.

2. Please take this form to a physician licensed to practice medicine in the State of North Carolina or any state of the United States for completion. Your physician will only need to complete theappropriate part(s) of this form that pertains to your health.

3. Please mail the completed form to the Division of Motor Vehicles Medical Review Unit, 3112 Mail Service Center, Raleigh, NC27697-3112. You may also fax this information to (919) 733-9569, (919) 861-3570 or (919) 861-3836

   This information is required to determine your ability to safely operate a motor vehicle. Failure to submit the required medical information within 30 days of the date of this letter will result incancellation or denial of your driving privilege. If additional time is needed, you may contact this office for consideration.


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NORTH CAROLINA DIVISION OF MOTOR VEHICLES
DRIVER LICENSE SECTION
CONSENT/INFORMATION FORM

Name: _____
Address: _____
City: _____
Customer No. _____

Date of Birth_____Race_____Sex_____County _____

I hereby authorize Dr./Counselor_____to give any examination they deem necessary for the purpose of determining my physical fitness to operate a motor vehicle. I understand this authorization includes permission for this information to be reviewed by a medical advisor approved by the Division for the purpose of a recommendation to be rendered to determine my driving needs and abilities.

SIGNATURE OF APPLICANT: _____
PARENT/GUARDIAN IF MINOR:_____

Telephone No.:Home ( )_____Business( )_____
Are you Retired Disabled Occupation:_____
What type of vehicle do you drive? Automobile School Bus_____
Commercial Motor Vehicle Other_____
Does your job require driving? _____
_____

To Physician

When completing the Medical Report Form, please keep in mind the physical, mental, and emotional requirements necessary for the safe operation of a motor vehicle, for the patient and public welfare. Please answer all questions and applicable parts of PP. 2-7, which lists the review of conditions pertinent to driving. If you circle "Yes" for any of these conditions, you should address all the questions pertaining on the proceeding pages. You do not need to answer questions on the form for which you circled "No". Upon completion of this form please make an overall statement about your patient's medical condition and its potential effect on safe driving.

CUSTOMER NO:

PATIENT'S MEDICAL HISTORY (Please complete in black ink):

A. If the patient has been hospitalized in the past two years, please give location, dates and discharge diagnoses. _____

_____

_____

B. How long has applicant been your patient? _____
Date you last treated patient before today? _____

C. Names of other physicians who have treated applicant in past two years:

_____

D. What is patient's height?_____weight?_____B.P. _____

E. ARE YOU TREATING THIS PATIENT FOR ANY OF THE FOLLOWING MEDICAL CONDITION(S)? IF YES, PLEASE COMPLETE APPROPRIATE PAGE(S).

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| VISUAL IMPAIRMENT? If yes, p.3 to be completed by Optometrist or Ophthalmologist | | | EMOTIONAL/MENTAL ILLNESS? If yes, complete entire section p.5 | | |
| CARDIOVASCULAR DISORDER? If yes, complete entire section p.4 | | | MUSCULOSKELETAL DISORDER? If yes, complete entire section p.5 | | |
| ENDOCRINE DISORDER? If yes, complete entire section p.4 | | | ANY OTHER IMPAIRMENT? If yes, complete entire section p.5 | | |
| RESPIRATORY DISORDER? If yes, complete entire section p.7 | | | SUBSTANCE ABUSE PROBLEM? If yes, complete entire section p.6 | | |
| NEUROLOGIC DISORDER? If yes, complete entire section p.7 | | | | | |

F. TO BE ANSWERED BY PHYSICIAN LICENSED TO PRACTICE MEDICINE IN THE U.S.:

1. In your opinion, has the patient followed your medical recommendations? Yes_____No _____
2. Are periodic medical evaluations for highway safety purposes recommended for patient? Yes_____No_____If yes, how often?_____
3. Do you feel the patient is medically fit to drive a car? Yes_____No _____
4. Do you feel the patient is medically fit to drive a CMV/SCHOOL BUS? Yes_____No _____
5. In your opinion, should patient be restricted to driving? If yes please specify_____miles radius of home, 45 mph/no interstate, daylight driving only, hand controls, corrective lenses, left foot accelerator, wheel knob, accompanied by class driver, t/f wk/ch/md/store, etc.

   _____
6. Do you recommend a road test? Yes_____No _____
7. Do you recommend an Occupational Therapist Evaluation? Yes_____No _____
8. Has the driver been involved in a recent motor vehicle accident because of their medical conditions? _____

Give your overall assessment of this patient's medical condition and any potential effect on safe driving. Please comment on all medical conditions, and any over-the-counter or prescription medications that might exacerbate the risk of driving. _____

_____

Physician's Signature:_____MD,NP,PA Date of exam:_____
Print Physician Name:_____Phone Number (____)_____
Physician's Specialty: _____
Address:_____City/Zip: _____

CUSTOMER NO:

I,_____, hereby authorize Dr._____to provide my examination information for the purposes of determining my visual fitness to operate a motor vehicle. I understand this authorizes the Division's panel of physicians to review my case.

Applicant Signature_____License/Cust No._____
Parent/Guardian if Minor_____Telephone Number_____

TO BE COMPLETED BY A LICENSED OPHTHALMOLOGIST OR OPTOMETRIST

1. What is the vision diagnosis? _____
2. Which eye(s) are affected? ____Right_____Left_____Both
3. Is the condition:_____Permanent_____Stable_____Worsening_____Improving
4. Best corrected Visual Acuity: 20/___Both 20/___Right 20/___Left
5. Uncorrected Visual Acuity: 20/___Both 20/___Right 20/___Left
6. New lenses prescribed? ____Yes_____No
7. Are corrective lenses recommended to drive? ____Yes_____No

8. What is the horizontal field of view in each eye w/out field expanders?
   Right:_____nasal_____temporal Left:_____nasal_____temporal
   Test used:_____Confrontation_____Goldmann_____Automated
9. Are there other visual issues that might affect driving?
   ____No_____Depth Perception_____Diplopia ____Contrast Sensitivity
   ____Glare sensitivity_____Other:_____
10. Is a bioptic telescope used for driving?_____Yes_____No (skip to #16)
11. If yes, how long has it been used? ____New Duration:_____mo/yrs
12. If yes, for which eye(s)? (Circle) Right Left Both
13. Visual acuity through bioptic telescope:_____Right_____Left_____Both
14. Has the individual driven previously without a bioptic telescope? Y N
15. Has the individual completed training in the use of a bioptic for driving?_____Yes_____No
16. Are there any other concerns regarding this individual's fitness to safely operate a motor vehicle?_____No_____Cognitive_____Physical
    ____Psychological____Other:_____
17. What driving restrictions (if any) do you recommend based upon your examination?_____None_____45mph limit/no interstate ____Daylight Only
    Local driving only:_____miles from home ____Should not drive
18. Other recommendations:

    ____Periodic vision evaluation:_____6 months_____every: 1 2 3 years(s)
    ____On road evaluation by DMV (or approved examiner)
    ____Recommend DMV follow-up? _____Yes _____No
    ____Other: _____

Vision Examiner:
Name_____Degree_____License #_____
Address_____
_____
Phone_____Fax_____
Signature_____Date of exam _____

CUSTOMER NO:

********** CARDIOVASCULAR **********

1. What is the diagnosis? _____
   Date of onset: _____

2. Check AHA Cardiovascular Functional Class: I____II____III____IV_____

3. Does patient have arrhythmia that alters mental or physical functions?
   Yes No If yes, how often? ___
   _____ What is the severity and does it cause syncope?
   _____ Is it controlled? Yes_____No _____

4. Does patient currently use a pacemaker? Yes_____No _____

5. Does the patient currently use an automatic implantable cardioverter-defibrillator? Yes____No____If yes, give date of surgery_____
   Date(s) of hemodynamically significant arrhythmia events post-op:
   _____

6. Has the patient had cardiac surgery? Yes_____No _____
   Date and type of operation _____
7. Has the patient had CHF? Yes No Is CHF controlled? Yes _____No _____

8. List current medications:_____
9. Assess compliance with medications: Excellent_____Good_____Poor_____

********** ENDOCRINE/DIABETES **********

1. What is the diagnosis?_____
   Date of onset_____HgbA1C Level_____Therapy_____

2. If patient has experienced significant hypoglycemia in past year give dates of last episodes:_____

3. What is the patient's attitude toward treatment?
   Accepts and complies_____Non-compliant _____

4. Does the patient have any current or past systemic effects of diabetes and if so comment on its effect on driving? _____
   _____
   _____

5. Is the patient aware of the early warning signs of hypoglycemia and are reliable in taking necessary precautions to avoid hypoglycemia? Yes No

6. List current medications:_____
7. Assess compliance with medications: Excellent_____Good_____Poor_____

Physician's Signature:_____Date _____

CUSTOMER NO:

********** MENTAL OR EMOTIONAL **********

1. What is the diagnosis?_____Date of Onset_____
2. When and where was patient treated for this condition?_____
   _____
3. What is patient's current status? Recovered____Partially Controlled_____
   Intermittently Controlled Inadequately Controlled Fully Controlled_____
4. Does patient have memory problems? Yes_____No_____
   If yes, to what degree? Mild_____Significant_____Severe_____
5. What is patient's mental capacity? Average or above_____
   Below Average_____Limited_____
6. Do you believe that this patient's mental or emotional illness poses a driving risk to himself/herself or others? Yes____No_____
7. List current medications:_____
8. Assess compliance with medications: Excellent_____Good_____Poor_____

********** MUSCULOSKELETAL **********

1. What is the diagnosis?_____Date of Onset?_____
2. Describe extent of impairment and prognosis_____
   _____
3. Is it progressive? Yes____No_____
4. Indicate percent of function (full range of motion equals 100%)

| RIGHT ARM | LEFT ARM | RIGHT LEG | LEFT LEG | NECK |
|---|---|---|---|---|
| _____% | _____% | _____% | _____% | ____% |

5. Indicate percent of strength (full range of motion equals 100%)

| RIGHT ARM | LEFT ARM | RIGHT LEG | LEFT LEG | NECK |
|---|---|---|---|---|
| _____% | _____% | _____% | _____% | ____% |

6. To what extent is coordination or reaction time impaired?
   None_____ Slight_____ Moderate_____ Severe _____
7. To what extent does patient's motion produce pain?
   None_____ Slight_____ Moderate_____ Severe _____
8. What spastic muscles does patient have? _____
   _____
9. What extremities are missing? _____
10. Do you recommend any assistive devices to compensate for your patient's disability? If so please advise:_____
    _____
11. Do you recommend an Occupational Therapist Evaluation? Yes____No_____
12. To what extent will the patient's musculoskeletal disorder impair driving? None_____Slightly_____Significantly_____Should not drive_____
    REMARKS: _____
    _____
13. List current medications:_____
14. Assess compliance with medications: Excellent_____Good_____Poor_____

********** OTHER IMPAIRMENTS **********

1. Are there other medical impairments? Yes____No_____
   If yes, describe:_____
2. List current medications:_____
3. Assess compliance with medications: Excellent_____Good_____Poor_____

Physician's Signature:_____Date _____

CUSTOMER NO:

********** SUBSTANCE ABUSE **********

NOTICE: Recommendations for licensure for persons suspected of having substance abuse disorders will largely be made on the basis of their medical and other relevant records and documents.

1. Is the patient aware that driving with ANY amount of alcohol in their system is likely to affect driving performance and increase the risk of injury? Yes_____No_____
2. Has the patient ever been charged with driving while impaired (DWI)? Yes_____No_____If yes, how many convictions? _____
3. At what age did the patient start drinking alcohol? _____
4. How often does (or did), patient drink?
   Daily_____Weekly_____Monthly_____Binge _____
5. How much does (or did), patient drink at a time?
   1-2 drinks_____3-4 drinks_____5 or more drinks_____Pint _____
6. How many times a year does (or did), patient drink enough to affect speech, walking, driving, or other activities? _____
7. Did the patient ever completely stop drinking? Yes_____No_____
   If yes, give the date(s) length of time stopped:_____
8. What was the date of patient's last drink(Beer,Wine,Whiskey)?_____
9. Has patient ever had a drinking problem? Yes_____No_____
10. Does the patient believe that he/she can still drink without causing problems? Yes_____No_____If yes, why?_____
11. Has patient ever abused other drugs (illicit/prescription)? Yes____No_____
    If yes, give drugs and describe extent of usage:_____
    _____
12. Describe patient's current use of drugs and/or medications:_____
    _____
13. When did patient last abuse drugs? _____
14. Which of the following types of substance abuse education, treatment, or rehabilitation programs has patient SUCCESSFULLY COMPLETED?
    _____ADETS (Alcoh. Drug Ed. Traffic Sch.) Dates:_____to _____
    _____Alcohol Rehabilitation Center Dates:_____to_____
    Name: _____
    _____Mental Health Program Dates:_____to _____
    _____Alcoholics Anonymous Dates:_____to_____Sponsor? Yes____No_____
    Approximate number of sessions: _____
    _____None: The patient did not complete a substance abuse program.
15. Have you recommended that this patient seek help? Yes_____No _____
16. Is patient actively involved in any social or other type of health aid program such as mental health, private counseling, Alcoholics Anonymous, etc.? If yes, please complete the following:
    Name of program: _____
    Address:_____Telephone: (____)_____
17. Does the patient have sufficient support for maintaining sobriety?
    ____Yes _____No
18. Is the patient using Methodone or Naltraxone?_____Yes ____No

Physician's Signature:_____Date _____

CUSTOMER NO:

********** RESPIRATORY **********

1. What is the diagnosis? _____
   Medications _____
2. What is the degree of severity? Mild _____ Moderate _____
   Severe (pa02<60mmHg) _____ Debilitating _____

   **NOTE: IF pa02 IS LESS THAN 60mmHg, PLEASE OBTAIN AND ATTACH ROOM AIR ARTERIAL BLOOD GAS IF NOT CONTRAINDICATED.
3. Does patient use oxygen while driving? Yes_____No _____
4. Oxygen saturation levels _____
5. Does patient use a CPAP machine? Yes_____No _____
   **NOTE:If Physician checked "YES" to question #5 please attach a copy OF YOUR CPAP COMPLIANCE REPORT FOR THE LAST YEAR**

********** NEUROLOGIC **********

1. What is diagnosis? _____
   Date of onset: _____
2. Has patient suffered brain damage from trauma, cerebrovascular disease, stroke, or other cause? Yes_____No_____Has it resolved? _____
3. Has patient suffered impairment of any of the following:
   Mentation? Yes_____No_____ Memory? Yes_____No_____
   Judgment? Yes_____No _____ Emotional Stability? Yes_____No _____

   **NOTE: IF YOU CHECKED "YES" TO ANY OF THE ABOVE CATEGORIES, COMPLETE THE EMOTIONAL PORTION OF THIS FORM ON PG 5.
4. Has patient suffered impairment of any of the following:
   Muscular strength? Yes_____No_____Coordination? Yes_____No _____
   **NOTE: IF YOU CHECKED "YES" TO ANY OF THE ABOVE CATEGORIES, COMPLETE THE MUSCULOSKELETAL PORTION OF THIS FORM ON PG 5.
5. If patient has seizure disorder, what type? _____
   With seizure, is there any loss of consciousness? Yes No_____
   Date of onset:_____Number of seizures in last 2 yrs: _____
   Date of last:_____Aura? If yes, duration: _____
   Does the seizure occur during sleep only? Yes_____No _____
6. Is patient taking medication for his/her epilepsy or seizures?
   Yes_____No_____If yes, complete the following:
   List medications and dosage _____
   Date of last medication change_____Blood levels
   Date medication was discontinued Who discontinued _____
   Compliance with medication: Excellent_____Good_____Poor _____
7. Has the patient had an EEG: Yes_____No_____If yes, when:_____
   Interpretation: _____
8. Have there been other episodes of altered consciousness? Yes_____No_____
   If yes, give date, description and work-up: _____
   _____

Physician's Signature:_____Date _____

00 No physician-diagnosed disease of consequence
08 Automatic implantable cardioverter-defibrillator
11 Hypertension
12 Cardiovascular disorder
13 Valvular heart disease
14 Cerebrovascular accident(s)
15 Cardiac arrhythmias(s)
16 Peripheral vascular disease
17 Heart failure
18 Pacemaker
19 Cardiac surgery
20 Insulin-dependent Diabetes
21 Non-insulin-dependent Diabetes
22 Peripheral Neuropathy
25 Endocrine disorder(s)
30 Loss of consciousness or dizziness
31 Seizure disorder
32 Sleep disorder(s)
33 Multiple sclerosis
34 Parkinson's disease
35 Neuromuscular Disease
36 Non-Muscular Dystrophy Neuromuscular Disorder
37 Cerebral vascular malformations
38 Cerebral palsy
39 Paralysis - complete
40 Paralysis - partial
41 Traumatic brain injury
42 Brain neoplasm or tumor
45 Arthritis
46 Missing limb(s)
47 Neck or back pain
48 Musculoskeletal Impairment(s)
50 Hearing impairment
53 Homonymous Hemianopia
54 Bioptic Telescope Lenses
55 General Eye Condition
56 Corneal Impairment
57 Visual Field Impairment
58 Retinal Impairment
59 Nystagmus
60 Mental Health Condition
61 Psychotic Disorder
62 Mood Disorder
63 Anxiety disorders
64 Personality disorder
65 ALCOHOL-RELATED - ALL CASES CODED PRIOR TO 7/1/69
66 Alcohol misuses-no record of DWI
67 Alcohol misuse-DWI 18 months ago or more
68 Alcohol misuse-DWI less than 18 months
70 Substance use, misuse, or abuse
75 Intellectual or Developmental Disability
76 Encephalopathy
77 High risk driver
78 Cognitive Impairment
79 Emotional Disability

LDLSMRF00081

80 Respiratory disorders
90 Miscellaneous disease or impairment
91 Renal Disorder
92 Skin Disorder
93 Gastrointestinal Disorder
94 Genitourinary Disorder
95 Neurological Disorder
99 General Physical Condition