TEXAS
Health and Human Services

Texas Department of State Health Services

John Hellerstedt, M.D.
Commissioner

Dear Physician:

The attached forms have been brought to you by an applicant for, or current holder of, a Texas Driver license. This person's case has been referred to the Medical Advisory Board by the Texas Department of Public Safety (DPS) because of a concern (possibly self-identified) about the candidate's medical history.

If the identified medical problem is loss of consciousness, please explain cause in the appropriate section of the attached forms. If the medical problem is alcohol or drug abuse please just fill out that section of the form. If this is the first time you have seen this patient please record what the patient says was their last time using and state this is the first time you have seen this patient and this is what he's told you.

The Health and Safety Code authorizes the Medical Advisory Board to require the person to undergo an examination at his or her own expense. However, at this time we are simply calling for a thorough and current medical history, as it pertains to any medical limitations to driving. Current medical information is defined in rule as being less than six months old. An examination will be necessary if one has not been conducted within six months.

Please complete and return all pages of the ***Applicant Medical History Form*** along with the ***Authorization to Release Medical Information Form*** to:

Medical Advisory Board
Texas Department of State Health Services
Regulatory Licensing Unit/Medical Advisory Board
(MC 1876)
PO Box 149347
Austin, Texas 78714-9909

or

Fax to:

(512) 834-6736

Statute pertaining to medical liability protection, as it concerns any professional opinion, recommendation, or report you make for the purpose of assisting the Texas Medical Advisory Board in determining a candidate's ability to operate a motor vehicle, has been included on the Applicant Medical History Form.

If you have any questions about the forms or the procedure, please call (512) 834- 6738 or (512) 834-6739.

Medical Advisory Board
Texas Department of State Health Service

TEXAS Health and Human Services

Texas Department of State Health Services

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Commissioner

MEDICAL ADVISORY BOARD
Texas Department of State Health Services

AUTHORIZATION TO RELEASE MEDICAL INFORMATION FORM
for
Driver's License Applicants

I authorize the following Health Care Provider: (Individual, Physician, Hospital, Clinic, Public Health Dept., etc.)

_____

_____
Address/City/State/Zip

to provide the confidential health and medical information in my clinical records necessary for the Texas Medical Advisory Board (MAB) to determine my present fitness to exercise sound judgment with respect to the safe operation of a motor vehicle, as it relates to the driver's license vehicle class for which I have applied. Such information should include any information on any conditions that cause or are likely to cause substantial impairment in the patient's ability to safely operate a motor vehicle. This information should be released to the:

The information furnished by the named health care provider to the designated individual and any reports prepared by the MAB may be released by the individual, or the Texas Department of State Health Services in the manner and for the purpose permitted in the Health and Safety Code, Chapter 12, Sections 091 - 098, and the rules of the Texas Board of State Health Services adopted pursuant to the above stated law to govern the activities of the MAB.

I understand I am to pay any professional fees connected with this examination.

This authorization to the Medical Advisory Board and the Texas Department of State Health Services is effective until the receipt by the department of a written withdrawal notice from me. This form has been read by me or has been read to me and I understand its meaning. **Information provided must be based on an examination within the last six months.**

Signature of applicant/licensee: _____ Date:_____
Print name of applicant/licensee: _____
Drivers license number: _____

Signature of person authorized to consent (if not applicant): _____

Print above name: _____ Date: _____
Relationship to applicant/licensee: _____

This page to be **completed by applicant** and given to physician to return to the Medical Advisory Board.

Physician, please return completed forms to:

Medical Advisory Board
Texas Department of State Health Services
Regulatory Licensing Unit/Medical Advisory Board
(MC 1876)
PO Box 149347
Austin, Texas 78714-9909

or

Fax to: (512) 834-6736

Rev: 1/2018

TEXAS Health and Human Services

Texas Department of State Health Services

John Hellerstedt, M.D.
Commissioner

APPLICANT MEDICAL HISTORY FORM
To be completed by a licensed physician

Texas Department of State Health Services
Medical Advisory Board

Physician to return this original form to the Medical Advisory Board with Authorization to Release Medical Information

The Texas Department of Public Safety has requested that the Medical Advisory Board assist them in the evaluation of the case of:

_____ _____
First name Middle

_____
Last

Drivers license number _____

as it pertains to his/her license to operate a motor vehicle. This evaluation concerns a possible medical limitation which could adversely affect his/her ability to operate a motor vehicle. Authority to perform this review is in accordance with the Transportation Code, Chapter 521, Section 321, the Health and Safety Code, Chapter 12, Sections 091 - 098, and the implementing rules adopted by the Texas Department of State Health Services.

Health and Safety Code, Title 2, Subtitle A, Chapter 12, Subchapter H
Medical Advisory Board
Sec. 12.098. Liability.
A member of the medical advisory board, a member of a panel, a person who makes an examination for or on the recommendation of the medical advisory board, or a physician who reports to the medical advisory board or a panel under Section 12.096 is not liable for a professional opinion, recommendation, or report made under this subchapter.
Added by Acts 1995, 74th Leg., Ch. 165, Sec. 9, eff. Sept. 1, 1995.

Full name of applicant/licensee: First_____ Middle_____

Last_____ Driver's License Number:_____

Provide specific information on the following medical condition:

PATIENT MEDICAL HISTORY

I. Has the patient been hospitalized within the past two years for problems related to this evaluation? Yes ( ) No ( )

If so, when? _____

_____

Where? _____

_____

Reason? _____

_____

Physician/s _____

_____

First_____ Middle_____ Last_____ DL Number: _____

Physician to return this original form to the Medical Advisory Board with Authorization to Release Medical Information

II. Please note the presence of abnormalities in the following applicable categories.

A. Cardiovascular ☐ Does not apply to this patient

1. Blood pressure _____
   Dyspnea _____
   Angina _____
2. Pacemaker _____
   Date Installed _____
3. Syncope _____
   Date _____
   Frequency _____
4. Stroke _____
5. Functional Capacity _____
6. Pulse _____ Defibrillator_____
7. AHA

Functional Capacity_____

Check one:

☐ Class 1 No limitation physical activity
☐ Class 2 Slight limitation physical activity
☐ Class 3 Marked limitation physical activity
☐ Class 4 Complete limitation physical activity

Therapeutic Capacities

☐ Class A: No restrictions
☐ Class B: Restricted from strenuous activities
☐ Class C: Slight restriction of normal activity
☐ Class D: Severe restriction of activity
☐ Class E: Complete bed rest

Angina pectoris should be characterized by the Canadian Cardiovascular Society classification and heart failure by the New York Heart Association classification.

Angina Pectoris

☐ Class 0: Asymptomatic
☐ Class 1: Angina with strenuous exercise
☐ Class 2: Angina with moderate exertion
☐ Class 3: Angina with mild exertion
   1. Walking 1-2 level blocks at normal pace
   2. Climbing 1 flight of stairs at normal pace
☐ Class 4: Angina at any level of physical exertion

Diagnosis:

Heart Failure

☐ Class I (mild): No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation or dyspnea (shortness of breath).
☐ Class II (mild): Slight limitation of physical activity. Comfortable at rest but ordinary physical activity results in fatigue, palpitation or dyspnea.
☐ Class III (moderate): Marked limitation of physical activity. Comfortable at rest but less than ordinary activity causes fatigue, palpitation or dyspnea.
☐ Class IV (severe): Unable to carry out any physical activity without discomfort. Symptoms or cardiac insufficiency at rest. If any physical activity is undertaken, discomfort is increased.

B. Neurological ☐ Does not apply to this patient

1. Date of last seizure _____ 2. Seizure frequency_____ 3. Are you concerned that the epilepsy or the anticonvulsants are interfering with cognitive abilities or processing speed Yes ☐ No ☐ 4. TIA or functional impairment _____ 5. Recurrent TIA's _____Functional Capacity_____ 6. Hemianopia? _____ 7 Dementia? Yes☐ No ☐ 8. Mild Cognitive Impairment? Yes☐ No☐ 9. Was a DPS written & driving test recommended? Yes ☐ No ☐ 10. Blackout?....Yes ☐ No ☐ Reason for Blackout. _____ Date of Blackout:_____ 11. Sleep Apnea_____ 12. AHI score _____	Diagnosis:

C. Metabolic ☐ Does not apply to this patient

1. Controlled by medication: Oral ☐ Insulin ☐ Type/dosage _____ Date begun _____ 2. Coma☐ Shock☐ Date of last coma/shock_____ Frequency _____ 3. Hypoglycemic incident Yes ☐ No☐ Date:_____	Diagnosis:

First_____ Middle_____ Last_____ DL Number: _____

Physician to return this original form to the Medical Advisory Board with Authorization to Release Medical Information

D. Medication that would impact driving ☐ Does not apply to this patient

1. Medication: Type/dosage/Date Begun:_____	Diagnosis:
_____	
_____	
_____	
_____	
_____	
_____	

E. Behavioral Health/Mental Health

☐ Does not apply to this patient

1. Psychiatric Treatment _____ _____	Diagnosis:
A. Hospitalized _____	
B. When _____	
C. Where _____	
D. Judgment _____	
E. Mental state at time form filled out:	
1.☐ Homicidal 2.☐ Assaultive	
3.☐ Suicidal 4.☐ Accident-prone	
5.☐ Impulsive 6.☐ Intellectual Disability: IQ _____	
F. Describe medication side effects subject is experiencing:	

F. Musculoskeletal ☐ Does not apply to this patient

1. Stiff or flail joints _____ Where _____	Diagnosis:
2. Spastic or paralyzed muscles _____ Where _____	
3. Amputation _____ Where _____	
4. Do they use a modification? Yes ☐ No ☐	
5. Are they trained using modification? Yes ☐ No ☐	
6. Appliances or supports: _____ Where _____	

First_____ Middle_____ Last_____ DL Number: _____

G. Vision

☐ Does not apply to this patient

1. Acuity: Without correction RE 20/_____LE 20/_____ With present correction RE 20/_____LE 20/_____ With best correction RE 20/_____LE 20/_____ 2. If visual acuity is less than 20/30, state cause of visual loss 3. Diplopia _____ Visual field loss _____ 4. Other eye abnormalities _____ 5. Medication: Type/dosage _____ Date begun _____	Comments:

H. Alcohol – Drug Use/Abuse

☐ Does not apply to this patient

1. Number of times treated _____ 2. When treated _____ Where treated _____ 3. Drugs abused _____ 4. Length of dependency _____ 5. Last known episode of abuse _____ 6. Member of Alcoholics/Narcotics Anonymous? _____ 7. Methadone/Antabuse? _____ Dispensing clinic _____ 8. Present medication/s _____ Type/dosage _____ 9. Prognosis:	Comments:

First_____ Middle_____ Last_____ DL Number: _____

A. How long treated _____ Last treated _____
B. Date of this exam _____

IV. Any recommendations or specific comments regarding driving capability, residuals, or other limiting conditions not previously noted:

_____

_____

_____

V. Signature of Physician _____Date_____

Name of Physician (print) _____

Address _____Telephone _____

City _____ State _____ Zip _____

State License Number _____Specialty _____

(Internal use)

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