DL-129 (4-12)

LOSS OF CONSCIOUSNESS AND/OR AWARENESS FORM

pennsylvania
DEPARTMENT OF TRANSPORTATION

PLEASE TYPE OR PRINT ALL INFORMATION IN BLUE OR BLACK INK

Bureau of Driver Licensing • P.O. Box 68682 • Harrisburg, PA 17106-8682 • (717) 787-9662

THIS FORM APPROVED BY THE MEDICAL ADVISORY BOARD 4/13/12
Provider: For more information relating to Medical Reporting, visit http://www.dmv.state.pa.us/centers/medicalReportingCenter.shtml.

PATIENT INFORMATION (Please complete this form in its entirety)

DRIVER'S LICENSE NO.	LAST NAME(S)	JR./ETC	FIRST NAME

HEIGHT		SEX	EYE COLOR	DATE OF BIRTH			TELEPHONE NUMBER	E-MAIL (if applicable)
FEET	INCHES			MONTH	DAY	YEAR		

STREET ADDRESS: P.O. Box number may be used in addition to the actual address, but cannot be used as the only address.	CITY	STATE	ZIP CODE

1. How long have you been treating this patient? _____
2. For what diseases or conditions has the patient been diagnosed? _____
   _____
3. Has this patient had multiple episodes of loss of consciousness? _____
   If yes, list the dates of the last <u>two</u> episodes: _____
   _____
   _____
4. Has this patient had multiple episodes of loss of awareness which would make him/her unsafe to drive? _____
   If yes, list the dates of the last <u>two</u> episodes: _____
5. What diagnostic tests were performed? _____
   What were the results? _____ Date of test(s)? _____
6. What caused the episode(s)? _____
   If it was vasovagal, what was the trigger? _____
   Do you feel it will impair his/her ability to drive? _____
7. What signs and symptoms does the patient have? Discuss nature, extent, and frequency.
   _____
   _____
8. Is the patient being treated with medication? . . . . . ❑ Yes ❑ No
   a. If yes, does the medication make him/her an unsafe driver? . . . . . ❑ Yes ❑ No
   b. If no, how is this condition(s) being addressed? _____

HEALTH CARE PROVIDER INFORMATION (Please print or type)

HEALTH CARE PROVIDER'S NAME	SPECIALTY	HEALTH CARE PROVIDER'S LICENSE NUMBER	
STREET ADDRESS	CITY	STATE	ZIP CODE
TELEPHONE NUMBER	FAX NUMBER		

I hereby state that the facts above set forth are true and correct to the best of my knowledge, information and belief. I understand that the statements made herein are made subject to the penalties of 18 Pa. C.S. § 4904 (relating to unsworn falsification to authorities) punishable by a fine up to $2,500 and/or imprisonment up to 1 year.

_____ _____
Health Care Provider's Signature Date