MEDICAL EXAMINATION REPORT

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Wisconsin Department of Transportation
Medical Review
PO Box 7918, Madison, WI 53707-7918
Telephone: (608) 266-2327
FAX: (608) 267-0518
Email: dmvmedical@dot.wi.gov

APPLICANT: After this medical report has been reviewed, you may be required to file medical reports on a regular basis. We will send you the forms at the time they are required.

Applicant Name		Operator License Number
Street Address		Birth Date (m/d/yy)
City, State ZIP Code		(Area Code) Telephone Number
Date Report Issued (m/d/yy)	WisDOT Examiner Badge Number	License Type ☐ CDLI ☐ Passenger Bus ☐ Instruction Permit ☐ Operator ☐ CDL ☐ School Bus

Reason for Referral

HEALTH CARE PROFESSIONAL: Please complete all pertinent sections relative to this person's health to assist the Department in making a licensing decision.

- ☐ **Driver Condition** or **Behavior Report** Attached. Driving Incident/Accident Date(s):_____.
- ☐ **General Medical**: complete sections **A** and **G** (others if appropriate)
- ☐ **Mental / Emotional**: complete sections **A**, **B**, and **G**
- ☐ **Neurological**: complete sections **A**, **C**, and **G**
- ☐ **Endocrine (Diabetes)**: complete sections **A**, **D**, and **G**
- ☐ **Cardiovascular**: complete sections **A**, **E**, and **G**
- ☐ **Pulmonary**: complete sections **A**, **F**, and **G**

SECTION A HEALTH CARE PROFESSIONAL - To Complete for ALL Applicants

Provide Diagnoses, Medications Used, and Dosages:	Height
	Weight

YES NO

1. ☐ ☐ Is the person's condition currently stable? **If not, explain below.**
2. ☐ ☐ Is the person reliable in following the treatment program? **If not, explain below.**
3. ☐ ☐ Does this person experience side effects of medication which are likely to impair driving ability? **If yes, explain below.**
4. ☐ ☐ Has this person experienced an episode of altered consciousness or loss of bodily control during the past 12 months? **If yes, explain below and give date.**
5. ☐ ☐ Does current alcohol/drug abuse/use interfere with medical condition? **If yes, a substance evaluation will be required.**
   - ☐ ☐ a. Did the person have a seizure(s) related to withdrawal? **If yes, explain below and give date.**
6. ☐ ☐ Does this person experience uncontrolled sleepiness associated with sleep apnea, narcolepsy, or other disorder? **If yes, explain below.**
7. Is driving ability likely to be impaired by limitations in any of the following?
   - ☐ ☐ a. Judgment and insight
   - ☐ ☐ b. Problem-solving and decision-making
   - ☐ ☐ c. Emotional or behavioral stability
   - ☐ ☐ d. Cognitive function or memory loss
8. Is driving ability likely to be impaired by limitations in any of the following?
   - ☐ ☐ a. Reaction time
   - ☐ ☐ b. Sensorimotor function
   - ☐ ☐ c. Strength and endurance
   - ☐ ☐ d. Range of motion
   - ☐ ☐ e. Maneuvering skills
   - ☐ ☐ f. Use of arm(s) and/or leg(s)

Details and Elaboration

Note: **Sections B, C and D are on the next page (over).**

SECTION B MENTAL / EMOTIONAL

YES NO

☐ ☐ 1. Has the person been hospitalized in the past year for a mental/emotional condition? **If yes, give admission date(s), reason(s) for admission and date(s) of discharge:** _____

_____

2. Identify current treatment program(s), counseling, etc. _____

_____

_____

SECTION C NEUROLOGICAL

Medical Examiner: To be considered for a license, the medical examination must be **at least 60 days after the episode**. If last episode occurred within the past 90 days, the patient is not eligible to hold a license.

YES NO

1. Give date of last episode of altered consciousness or loss of bodily control. **Date:** _____ (m/d/yy)

☐ ☐ 2. Does this person have a seizure disorder? **If not, explain cause and/or diagnosis related to episode(s).**

_____

3. List anticonvulsant medication: _____ . If discontinued, give date: _____

☐ ☐ 4. Was the last medication blood serum level within acceptable range?

☐ ☐ 5. Does this person's neurological condition involve movement disorder? If yes, please explain: _____

_____

6. If this person holds or is applying for a commercial driver license, and has had an episode of altered consciousness or loss of bodily control since the last report was filed with WisDOT, the following is required:
   a. A narrative summary, including the history of the episode(s);
   b. An indication of risk for further episodes;
   c. Current blood levels of anticonvulsant medication;
   d. Results of the most recent EEG.

SECTION D ENDOCRINE

1. Please provide a hemoglobin A_1C reading: _____
   (Reading) (Date)

YES NO

☐ ☐ 2. Does this person have hypoglycemic reactions requiring assistance?
If yes, please explain frequency and provide date of last reaction: _____

☐ ☐ 3. Does this person demonstrate how to counter these reactions?

☐ ☐ 4. Has this person been hospitalized for treatment of diabetes or complications in the past year? If yes, explain below:

_____

5. Indicate type of medication and dosage for current treatment. _____

_____

☐ ☐ 6. Is this person experiencing renal failure? If yes, what is their current treatment regimen? _____

_____

☐ ☐ 7. Does this person monitor his/her blood sugar?

8. Provide the last 3 fasting blood sugar readings and dates recorded. (Home monitoring results ARE acceptable.)

_____ (Reading) _____ (Date) _____ (Reading) _____ (Date) _____ (Reading) _____ (Date)

9. If this person holds or is applying for a commercial driver license, and is taking insulin in the past 2 years, please provide the following information:
   a. When was this person diagnosed with diabetes? _____

YES NO
   b. When was insulin first prescribed? _____

☐ ☐ c. Do any complications or associated conditions exist? If yes, please explain: _____

_____

SECTION E CARDIOVASCULAR

1. Functional Class
   ☐ I ☐ II ☐ III ☐ IV

YES NO

☐ ☐ 2. Does the person have an implantable cardioverter defibrillator? If yes, give implant date: _____

☐ ☐ 3. Has the unit discharged since the implant? If yes, describe the person's condition at the time and date of discharge.

_____

_____

Has this person had any of the following? Please explain any yes answers.

YES NO

☐ ☐ 4. Cardiovascular surgery and/or other procedures. Describe and give date(s) _____

_____

_____

_____

5. List all current cardiac symptoms _____

_____

_____

☐ ☐ 6. Syncope due to cardiovascular condition: _____

☐ ☐ 7. Dyspnea at rest: _____

☐ ☐ 8. Fatigue at rest: _____

☐ ☐ 9. Have any cardiac tests been conducted (exercise stress test, etc.)? **If yes, give procedure(s), date(s), results.**

_____

_____

_____

_____

SECTION F PULMONARY

YES NO

☐ ☐ 1. Pulmonary Disease? If so, what? _____

☐ ☐ 2. Continuous Oxygen Use Required? If so, describe treatment regimen and provide number of liters.

_____

☐ ☐ 3. Dyspnea at rest?

☐ ☐ 4. Fatigue at rest?

☐ ☐ 5. Syncope from cough? Please explain cause and resolution: _____

_____

6. Provide Pulse Oximetry: Room Air _____ Oxygen _____

7. List Pulmonary Function Test Results

_____

_____

☐ ☐ 8. Does the pulmonary disease prevent activities of daily living? If yes, please identify. _____

_____

_____

_____

Note: Section G is on the next page (over).

SECTION G **HEALTH CARE PROFESSIONAL Recommendations for ALL Applicants**

Medical Examiner:

This report must be based on an examination conducted WITHIN THE PAST 90 DAYS or since _____.

The Secretary of the Department of Transportation is, by statute, responsible for the driver licensing decision. Your report will be advisory in determining eligibility. **Health Care Professional's signature AND ALL recommendations (Section G) are required for ALL applicants**.

YES NO

☐ ☐ 1. In your opinion, is this person medically safe to operate a motor vehicle?

☐ ☐ 2. In your opinion, is this person medically safe to operate a commercial motor vehicle?

☐ ☐ 3. In your opinion, is this person medically safe to operate a bus and/or school bus?

☐ ☐ 4. If YES to Question #1 above:
Do you recommend a complete re-examination of this patient's driving ability (knowledge, signs and skills test)?

☐ ☐ 5. If applicable, I reviewed the attached Driver Condition or Behavior Report..

☐ ☐ 6. Recommended Restrictions:

- ☐ Continuous Oxygen Use Required
- ☐ Daylight Driving Only
- ☐ Drive only _____ miles from home
- ☐ Other: _____

☐ ☐ 7. Do you recommend any additional medical evaluation?

I certify that I have examined this patient. My speciality is: _____

Print Name of Reporting Health Care Professional	Check One: ☐ MD ☐ PA-C ☐ DO ☐ APNP	**Patient** Examination Date
		Professional License Number
X (Signature of Reporting Health Care Professional)		(Area Code) Office Telephone Number

Pursuant to Chapter 448.01, Wis. Statutes and Trans Ch. 112.02, Wis. Admin. Code, this form must be signed by an MD, DO, PA-C or APNP.