Tasmania

ASSESSING FITNESS TO DRIVE - PATIENT QUESTIONNAIRE

Name	Address
· tallic	1 Luui Coo

IMPORTANT:

This form must be completed prior to attending your appointment. To be signed by you in the presence of your doctor.

		No	Yes	5.	Please circle the answer that is correct for	you:		
1.	Are you currently being treated by a doctor			5.1	How often do you have a drink containing	g alcohol?		
•	for any illness or injury?				3	o to Three	Four or	
2.	Are you receiving any medical treatment or taking any medication (either prescribed or otherwise) (Please take any medications with you to show the doctor)			5.2		es a week you have on	times a a typica	
3.	Have you ever had, or been told by a doctor that you				1 or 2 3 to 5 5 to 6	7 to 9	10 or n	nore
	had any of the following?			5.3				
	3.1 High blood pressure				Never Less than Monthly	Weekly	Daily	or
	3.2 Heart disease				monthly		almost	daily
	3.3 Chest pain, angina			5.4			ou were	not
	3.4 Any condition requiring heart surgery				able to stop drinking once you had started		Doile	
	3.5 Palpitations/irregular heartbeat				Never Less than Monthly monthly	Weekly	Daily almost	
	3.6 Abnormal shortness of breath			5.5	·	failed to do v		-
	3.7 Head injury, spinal injury				normally expected from you because of d	rinking?		
	3.8 Seizures, fits, convulsions, epilepsy				Never Less than Monthly	Weekly	Daily	
	3.9 Blackouts, fainting				monthly	1 1 6	almost	-
	3.10 Stroke			5.6	How often during the last year have you remorning to get yourself going after a heav			
	3.11 Dizziness, vertigo, problems with balance				Never Less than Monthly	Weekly	Daily	
	3.12 Double vision, difficulty seeing				monthly	,	almost	
	3.13 Kidney disease			5.7	e j	nad a feeling	g of guilt	t or
	3.14 Diabetes				remorse after drinking?	XX7 1.1	D "	
	3.15 Neck, back or limb disorders				Never Less than Monthly monthly	Weekly	Daily almost	
	3.16 Hearing loss or deafness or had an ear operation or use a hearing aid			5.8	·		to reme	mber
	3.17 Do you have difficulty hearing people on the telephone (including use of hearing				Never Less than Monthly monthly	Weekly	Daily almost	or
	aid if worn)?	ш		5.9	·	s a result of		aarry
	3.18 Have you ever had, or been told by a doctor that you had a psychiatric illness,	dialia - 9			o a resait or	jour		
	or nervous disorder				No Yes, but not in		Yes, du	ıring
	3.19 Have you ever had any other serious				the last year		the last	•
	injury, illness, operation, or been in hospital for any reason?			5.10	0 Has a relative or friend, or doctor or other concerned about your drinking or suggest			
	4.1 Have you ever had, or been told by a doctor that you had a sleep disorder,				No Yes, but not in		Yes, du	
	sleep apnoea, or narcolepsy?				the last year		the last	year
	2 Has anyone noticed that your				oring of the AUDIT questionnaire is shown in the suse on page 112)	section on Sub	stance	
	breathing stops or is disrupted by				,		No	Yes
	episodes of choking during your sleep?			6.	Do you use illicit drugs?			
	4.3 How likely are you to doze off or fall asleep in the fol situations, in contrast to feeling just tired? This refers			7.	Do you use any drugs or medications not			
usual way of life in recent times. Even if you haven'		t done			prescribed for you by a doctor?			
	some of these things recently try to work out how they have affected you.		ld	8.	Have you been in a vehicle crash since you last licence examination?	our		
Use the following scale to choose the most appropriate number for e		for eac	h		If Yes, please give details:			
	ion: $0 = would$ never doze off $1 = slight$ chance of	dozing	g					
	$2 = moderate \ chance \ of \ dozing \ 3 = high \ chance \ of \ dozing \ and $	_						
It is important that you put a number (0 to 3) in each of the 8 boxes.			Ap	plicant's Declaration (in presence of docto	or):			
Situa		dozing	(0-3)	-				
	g and reading				(Print name)	a tha abarra i	:f	ti a m
Watching TV				 declare that to the best of my knowledge supplied by me is true and correct 	e me above i	.mormat	uon	
Sitting, inactive in a public place (e.g. a theatre or meeting)			Sig	nature:	Date:	//_		
As a passenger in a car for an hour without a break				IMI	PORTANT: For privacy reasons the co	ompleted l	Examin	nation
Lying down to rest in the afternoon when circumstances permit					forma must not be returned to the Driv			
Sitting quietly often a lunch without alcohol			Medical information relevant to driver licensing should be included on the Medical Certificate (in the case of Driver Licensing Authority					
Sitting quietly after a lunch without alcohol					ated examinations) or on the Medical Con			Form
In a c	ar, while stopped for a few minutes in the traffic			(for	assessments made in the course of patient	ı treatment)•	

TO BE FILLED OUT BY MEDICAL PRACTITIONER

CLINICAL EXAMINATION PROFORMA

For use in Assessing Fitness to Drive for Commercial Vehicle Drivers.

The examiner will be guided by findings in the questionnaire or a referral letter and may apply appropriate tests other than those outlined here, e.g. **Mini Mental State** or equivalent for cognitive conditions. Findings relevant to the person's fitness to drive should be recorded on the Medical Certificate supplied by the Registrar of Motor Vehicles.

1.	Cardiovascular Sys	stem:		5	5.	Vision:				
	1.1 Blood Pressure	(repeat if necessary)			:	5.1 Visual Acu	ity			
	Systolic	mm Hg	mm Hg			Unco	rrected	Corr	ected]
	Diastolic	mm Hg	mm Hg			R	L	R	L	
	1.2 Pulse Rate:					6/	6/	6/	6/	
		Regular	☐ Irregular		١	- OI	0/	0/	0/	J
	1.3 Heart Sounds:					Are contact lens	ses worn?	No 🗆	Yes□]
		□ Normal	☐ Abnormal		:	5.2. Visual Fiel	ds (Confrontati	on to each eye)	:	
	1.4 Peripheral Puls	ses:					□Normal	l	□Abnor	nal
		□ Normal	□Abnormal	_						
				6	6. Hearing: (Commercial Drivers only)					
2	Chest/Lungs:						☐ Normal	l	□Abnor	nal
4.	Chest/Lungs.	□ Normal	□Abnormal							
				7		Urinalysis:				
2	Ab 1 (i)				,	7.1 Protein:				
э.	Abdomen (liver):	□Normal	□Abnormal		,	7.2.61	☐ Normal		□Abnor	nal
		□ Normai	□ Abilotiliai			7.2 Glucose:	☐ Normal	l	□Abnor	mal
										ııaı
4.	Neurological/Locor	notor		_						
	4.1 Cervical spine	rotation		8			gical Assessmer State Questions			pply
		□Normal	□Abnormal			Questionnaire o		iane or General	Health	
	4.2 Back movemen	nt								
		□ Normal	□Abnormal				Score:			
	4.3 Upper Limbs			_						
	(a) Appearance					RELE	EVANT CLI	NICAL FI	NDINGS	
		□Normal	□Abnormal				any relevant f			
	(b) Joint movement	ts					king reference essing Fitness t			standards
		□Normal	□Abnormal	- OI	utiii	ied iii tile Asso	ssing rimess i	.o Diive public	auon.	
	4.4 Lower Limbs									
	(a) Appearance									
		□Normal	□Abnormal							
	(b) Joint movement	is								
		□Normal	□Abnormal							
	4.5 Reflexes									
		□Normal	□Abnormal							
	4.6 Romberg's sign	1			IMI	PORTANT: F	or privacy rea	sons the comi	oleted Exami	nation
		s the ability to maintain ba ogether side by side, eyes ds):	_] 	Pro Med on t initi	forma must no lical informat he Medical Ce ated examinat	ot be returned on relevant to rtificate (in the ons) or on the N	to the Driver I driver licensin case of Driver Medical Condit	Licensing Aut g should be in Licensing Aution Notificatio	hority. Icluded Ithority
		1 (O111101	L / Wildillai		(for	assessments m	ade in the cour	se of patient tre	atment).	

This form must be retained by the examining doctor and is not to be returned to the Registrar of Motor Vehicles.