Print Form

Montana Department of Justice
MVD
Motor Vehicle Division
Safety • Efficiency • Dependability

Driver Medical Evaluation

P.O. Box 201430 Helena, MT 59620-1430 ● Phone (406) 444-3273 ● Fax (406) 444-1631 ● www.doj.mt.gov

Patient's Legal Name	Patient's Driver License No.			Patient's Birth Date
Patient's Mailing Address	City	State	Zip	Phone

A. INTRODUCTION TO PHYSICIAN

The Motor Vehicle Division records indicate your patient may have a condition that could affect the safe operation of a motor vehicle. With your assistance, we hope to resolve the matter with a minimum of inconvenience to all concerned. A report from an eye specialist is particularly valuable if a driver's fitness is questioned in court or following an accident. In some cases, examinations by more than one specialist are requested. Driver license examiners do not recommend or suggest physicians to applicants.

Your experience and knowledge of the patient's condition, results of medical examinations and treatment plans, will be of great value in assisting the department to determine a proper licensing decision. PLEASE ANSWER ALL QUESTIONS on this form that are applicable to your patient's condition. A physician reporting in good faith is immune from liability, civil or criminal penalties under Montana law MCA 37-2-311 and 37-2-312. The department has sole responsibility for any decision regarding the patient's driving qualifications and licensure. The department will also consider non-medical factors in reaching a decision.

Please complete this form for the examination you conduct. Leave blank any items not covered in your examination. If the case is unique, additional comments may be helpful. Attach a separate sheet if necessary.

The above individual is being referred to you due to: ANY CONDITION WHICH MAY INTERFERE WITH THE SAFE OPERATION OF A MOTOR VEHICLE

The physician assumes no responsibility in making this report, other than that of truthfully representing the facts. **For proper identification, have the patient sign the release authorization in your presence.**

Comments:

RELEASE OF INFORMATION BY PATIENT – SIGN IN PRESENCE OF PHYSICIAN

I hereby authorize my physician/provider or hospital to answer any questions from the Motor Vehicle Division, or its employees relating to my physical or mental condition, and/or drug and/or alcohol use or abuse, and to release any related information or records to the Motor Vehicle Division or its employees. Any expense involved is to be charged to me and not the State of Montana.

I hereby authorize the Motor Vehicle Division to receive any information relating to my physical or mental condition, and/or drug and/or alcohol use or abuse, and to use the same in determining whether I have the ability to operate a motor vehicle safely.

Signed: **X** _____ Date: _____

Witness: _____ Patient's Daytime or Home Phone Number: _____

B. DIAGNOSIS

Is the condition:			
○ Improving	○ Stable	○ Worsening or deteriorating	○ Subject to change
How long has this person been your patient?		Date of last examination:	
Is your patient under a controlled medical program? ○ Yes ○ No		How long has control been maintained?	

C. MEDICATIONS

Please list any medication currently prescribed:		
Would the side effects from the prescribed medication interfere with the safe operation on a motor vehicle? ○ Yes ○ No If yes, please describe:		

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D. LAPSE OF CONSCIOUSNESS OR CONTROL DISORDER

Please identify any disease or disorder including epilepsy, narcolepsy, diabetes, cerebral vascular disease, or any other impairment that may cause loss of consciousness or control of motor functions at any time:

Date of last episode: _____

Is condition stabilized? ○ Yes ○ No

E. IMPAIRMENTS THAT ARE PRESENTLY SHOWN BY YOUR PATIENT

- ○ Sporadic loss of conscious awareness
- ○ Impaired motor function
- ○ Reaction, or impairment due to change in medication or dosage
- ○ Neurological or neuromuscular disease
- ○ Diminished concentration
- ○ Diminished judgment
- ○ Memory Loss
- ○ Alzheimer's disease
- ○ Confusion
- ○ Other dementia
- ○ Other metabolic disorder

Comments: _____

F. IS YOUR PATIENT PHYSICALLY AND MENTALLY CAPABLE OF SAFELY OPERATING A MOTOR VEHICLE, IN YOUR OPINION?

○ Yes ○ No

If **NO**, please describe: _____

G. DO YOU RECOMMEND ANY DRIVING RESTRICTIONS OR ADAPTIVE EQUIPMENT FOR YOUR PATIENT? ○ Yes ○ No

If **YES**, please describe: _____

H. DO YOU RECOMMEND THE MOTOR VEHICLE DIVISION CONDUCT PERIODIC DRIVING EVALUATIONS OF YOUR PATIENT?

○ Yes ○ No

If **YES**, how often? _____

I. DO YOU RECOMMEND SUBMISSION OF PERIODIC MEDICAL REPORT TO MOTOR VEHICLE DIVISION BY YOUR PATIENT TO MONITOR CHANGES? ○ Yes ○ No

If **YES**, how often? _____

J. PHYSICIAN/PROVIDER

Signature:	Name (printed):	Date:
Type of Practice or Medical Specialty: Medical License Number:	Address:	Telephone Number:

Please return completed form to:

Motor Vehicle Division
Attn. Medical Unit
P.O. Box 201430
Helena, MT 59620-1430