



# Medical Assessment of Fitness to Drive

*This certificate is to be returned to the patient by the Health Professional*

Family Name: ..... Address: .....

Given Name/s: .....

Date of Birth:  Male  Female

**New Licence Application**       **Current Licence**      Licence Number: .....

Please indicate the type of licence held or applying for

Type	Motor Car	Light Rigid	Medium Rigid	Heavy Rigid	Heavy Combination	Multi-Combination	Motorcycle	Hire or Reward	Driving Instructor
Class	C	LR	MR	HR	HC	MC	R	"h"	"d"

## Medical Certificate

*(to be completed by Health Professional)*

Were you familiar with the patient's medical history before this examination?       Yes       No

Patient examined according to:       **Private Vehicle Standards**       **Commercial Vehicle Standards**

*I certify that I have examined the above mentioned patient in accordance with the relevant National Medical Standards (private or commercial) as set out in Assessing Fitness to Drive - September 2003. In my opinion the person subject to this report:*

Outcome	Action
<input type="checkbox"/> Meets all relevant criteria for an unconditional licence and requires no further assessment	No further information required
<input type="checkbox"/> Does not meet the medical criteria for an unconditional or conditional licence	Health Professional to advise in writing to: Driver Licensing Operations Coordinator GPO Box 530 Darwin NT 0801
<input type="checkbox"/> Does not meet the medical criteria for an unconditional licence, but may be suitable for a conditional licence based on opinion noted opposite. <i>Note that a conditional licence will not be issued unless adequate supporting information is provided by the examining health professional</i>	Examining Health Professional to note criteria not met, any other relevant medical details, any proposed restriction, any suggestions for management, any periodic review interval (for a conditional licence)  <b>(Please attach recommendations on a separate sheet)</b>
<input type="checkbox"/> Requires specialist assessment	Examining health professional to note type of specialist recommended or referred to.

Eyesight Test Result:    Left Eye: 6 / .....    Right Eye: 6 / .....    Both Eyes: 6 / .....

Reporting Professional's Name: ..... Examination Date:

Address: .....

Telephone: .....

Facsimile: .....

**Examining Health Professional's Signature**

**Medical certificates will not be accepted if more than 6 months has elapsed since the medical examination was performed.**

**The Registrar of Motor Vehicles has a legal responsibility to ensure that all drivers have the appropriate skills, abilities, and are medically fit to hold a driver licence. To meet this responsibility, legislation gives the Registrar of Motor Vehicles the authority to ask any driver licence holder or applicant to provide medical evidence of their suitability to drive and/or to undergo a driver assessment.**

## To the Driver/Applicant

- Make an appointment with your medical practitioner.
- As the examination may take longer than a routine consultation, please advise the receptionist when making the appointment that you are attending for this purpose.
- If you wear spectacles, hearing aids etc, please bring them to the examination.
- Take this form to the appointment for your doctor to complete.
- You are required by law to advise the Registrar of Motor Vehicles of any conditions that may affect your ability to drive. You should make the doctor aware of any medical conditions you may have so that your doctor can advise the Registrar of Motor Vehicles, on your behalf, using this form.
- If the medical report has been requested for a particular reason, you should let your practitioner know this reason.
- You should let your doctor know if you hold or are applying for a heavy vehicle or commercial licence, as the medical requirements for drivers of such vehicles are stricter.
- On completion of the examination the doctor will provide you with this form to return to the Motor Vehicle Registry.
- Payment for the medical examination is the responsibility of the licence holder/applicant.
- Withdrawal of Licence – If the Registrar of Motor Vehicles takes away your licence on the basis of a medical report, you may be re-licensed when you provide medical evidence indicating that you now meet the national medical standards. You should be aware that you have the right to seek a review of any decision affecting your licence.
- Any queries regarding licensing may be directed to the Motor Vehicle Registry on 1300 654 628.

## To the Health Professional

- The examination must be conducted in accordance with the national medical standards described in Assessing Fitness to Drive 2003.
- This publication is available on written request to Motor Vehicle Registry or via the web: <<http://www.austroads.com.au/aftd>>.
- On completion of the examination please fill in and sign the certificate overleaf.
- You should be aware of the patient's history prior to conducting the examination.
- Distribute the completed certificate as follows:
  1. Hand the original Medical Assessment of Fitness to Drive certificate (together with additional information relevant to the patient's fitness to drive) to the patient to present to the Motor Vehicle Registry.
  2. Retain a copy of the entire L2 package together with your detailed examination notes for the patient's medical record.
- If you have doubts about your patient's suitability to drive, you may suggest a driver assessment or referral to a suitable specialist. Please indicate this in the space provided. If you have any doubts about the information required, or wish to discuss the case personally, please contact the Driver Licence Operations Coordinator on 1300 654 628.
- **Indemnity** – Northern Territory legislation mandates reporting of unfit drivers by health professionals, thereby affording indemnity to practitioners who conduct an examination and provide Driver Licensing Authorities with an opinion based on that examination.
- **Criminal Liability & Insurance** – Health professionals may be liable under civil law in cases where a court forms the opinion that they have not taken reasonable steps to ensure that impaired drivers drive only in circumstances that do not place them and other members of the community at increased risk. Professional indemnity insurers are aware of the potential liability of health professionals and may reasonably expect health professionals to comply with the national medical standards.

Information not relevant to the patient's fitness to drive should **not** be forwarded to the Motor Vehicle Registry.

## Occupational Therapy Driver Assessment

- Trained occupational therapists may conduct a driver assessment where there is a medical concern about the patient's ability to drive safely.
- The aim of the occupational therapy assessment is to assist people with impairments to resume or continue driving. There are two components of the assessment.
- The first part of the assessment aims to evaluate the person's difficulties. This involves an interview, vision screen, cognitive function test, assessment of physical strength, motor skills, reaction time, road law and road craft. The need for specialist equipment or vehicle modifications is considered at this time.
- The on-road assessment takes a standard approach but can be designed to meet individual needs. It is conducted in a dual controlled vehicle, accompanied by a driving instructor and where necessary set up with special requirements or modifications to meet the needs of the client. The assessment is structured to assess the impact of injury, illness or the ageing process on driving skills such as judgement, decision-making skills, observation and vehicle handling.
- Provided the overall drive is safe, the 'bad habits' that an experienced driver might display may not result in failure.

### Conditions and Restrictions

- If appropriate, the practitioner may recommend conditions, which may enhance driver competency or safety and allow their patient to continue to drive (eg. corrective lenses, no night driving, additional mirrors).
- If the practitioner recommends a licence with conditions, details of the recommended restrictions and reasons must be provided, otherwise a licence will not be considered.
- If the practitioner believes that vehicle modifications are necessary (e.g. hand controls, left foot accelerator), or a prosthesis is necessary to drive safely, or that a local area driving restriction is appropriate, the patient may need to demonstrate the ability to drive safely with these restrictions. In these cases, a driver assessment is necessary.

### Motor Vehicle Registry Driver Assessment

- Where there is a concern about a person's ability to drive safely, a driving test may be necessary.
- Assessments of this nature are generally conducted in consultation with an Occupational Therapist trained in this area.

### Privacy Statement

The Registrar of Motor Vehicles is required to collect information for registrations, licences and permits under section 92 of the *Motor Vehicles Act*. The Registrar adheres to the Department's Privacy Statement and the *Information Act*. Further information on privacy can be found at [www.nt.gov.au/dlp](http://www.nt.gov.au/dlp)

# Patient Questionnaire

(to be signed in the presence of Health Professional)

To be retained by Health Professional and not returned to Motor Vehicle Registry

## IMPORTANT:

This Questionnaire must be completed by driver licence applicants where a medical assessment is routinely required for the class of licence sought, (e.g. Commercial Passenger Vehicle drivers, Driving Instructors etc.), or at the request of the Health Professional.

Name: .....

Date of Birth

Address: .....

/	/
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Please answer the following questions by ticking the correct box.

If you are not sure of the answer, leave the question blank and ask your health professional what it means.

Your health professional may ask you additional questions during the examination.

	YES	NO
Are you currently being treated by a health professional for any illness or injury?	<input type="checkbox"/>	<input type="checkbox"/>
Are you receiving any medical treatment or taking any medication (either prescribed or otherwise)? (Please take any medications with you to show the doctor)	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had, or been told by a doctor that you have had any of the following?		
High blood pressure .....	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease .....	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain, angina .....	<input type="checkbox"/>	<input type="checkbox"/>
Any condition requiring heart surgery .....	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations / irregular heart beat .....	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal shortness of breath .....	<input type="checkbox"/>	<input type="checkbox"/>
Head injury, spinal injury .....	<input type="checkbox"/>	<input type="checkbox"/>
Seizures, fits, convulsions, epilepsy .....	<input type="checkbox"/>	<input type="checkbox"/>
Blackouts, fainting .....	<input type="checkbox"/>	<input type="checkbox"/>
Stroke .....	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness, vertigo, problems with balance .....	<input type="checkbox"/>	<input type="checkbox"/>
Double vision, difficulty seeing .....	<input type="checkbox"/>	<input type="checkbox"/>
Colour blindness .....	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease .....	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes .....	<input type="checkbox"/>	<input type="checkbox"/>
Neck, back or limb disorders .....	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss, or deafness, or had an ear operation, or use a hearing aid .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have difficulty hearing people on the telephone (including use of hearing aid if worn) .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you had, or been told by a doctor that you had a psychiatric illness, or nervous disorder? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any other serious injury, illness, operation or been in hospital for any reason? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had, or been told by a doctor that you have had a sleep disorder, sleep apnoea, or narcolepsy? .....	<input type="checkbox"/>	<input type="checkbox"/>

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How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?

Use the following scale to choose the most appropriate number for each situation:

0 = would never doze off  
1 = slight chance of dozing  
2 = moderate chance of dozing  
3 = high chance of dozing

It is important that you put a number (0 to 3) in each of the 8 boxes.

Sitting and reading

Watching TV

Sitting, inactive in a public place (eg: a theatre or meeting)

As a passenger in a car for an hour without a break

Lying down to rest in the afternoon when circumstances permit

Sitting and talking to someone

Sitting quietly after a lunch without alcohol

In a car, while stopped for a few minutes in traffic

Please tick the answer that is most correct for you.

How often do you have a drink containing alcohol?

 Never Monthly Two to four times a month Two or three times a week Four or more times a week

How many drinks containing alcohol do you have on a typical day when you are drinking?

 1 or 2 3 to 5 5 to 6 7 to 9 10 or more

How often do you have six or more drinks on one occasion?

 Never Less than monthly Monthly Weekly Daily or almost daily

How often during the last year have you found that you were not able to stop drinking once you had started?

 Never Less than monthly Monthly Weekly Daily or almost daily

How often during the last year have you failed to do what is normally expected from you because of drinking?

 Never Less than monthly Monthly Weekly Daily or almost daily

How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

 Never Less than monthly Monthly Weekly Daily or almost daily

How often during the last year have you had a feeling of guilt or remorse after drinking?

 Never Less than monthly Monthly Weekly Daily or almost daily

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How often during the last year have you been unable to remember what happened the night before because you had been drinking?

- Never       Less than monthly       Monthly       Weekly       Daily or almost daily

Has you or someone else been injured as a result of your drinking?

- No       Yes, but not in the last year       Yes, during the last year

Has a relative, friend, a doctor, or other health worker been concerned about your drinking or suggested you cut down?

- No       Yes, but not in the last year       Yes, during the last year

- |  | YES                      | NO                       |
|--|--------------------------|--------------------------|
| Do you use illicit drugs?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you use any drugs or medications not prescribed for you by your doctor? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you been in a vehicle crash since your last licence examination?      | <input type="checkbox"/> | <input type="checkbox"/> |

If yes, please give details .....

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## Patient's Declaration

*(to be signed in the presence of Health Professional)*

I, .....  
(Print Name)

certify that to the best of my knowledge the above information supplied by me is true and correct.

Patient's signature: .....

Witness signature: .....