



ASSESSING FITNESS TO DRIVE - PATIENT QUESTIONNAIRE

Tasmania
DEPARTMENT of
INFRASTRUCTURE,
ENERGY and RESOURCES
Land Transport Safety Division

Name _____ Address _____

IMPORTANT:

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

	No	Yes
1. Are you currently being treated by a doctor for any illness or injury?	<input type="checkbox"/>	<input type="checkbox"/>
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)	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had, or been told by a doctor that you had any of the following?		
3.1 High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
3.2 Heart disease	<input type="checkbox"/>	<input type="checkbox"/>
3.3 Chest pain, angina	<input type="checkbox"/>	<input type="checkbox"/>
3.4 Any condition requiring heart surgery	<input type="checkbox"/>	<input type="checkbox"/>
3.5 Palpitations/irregular heartbeat	<input type="checkbox"/>	<input type="checkbox"/>
3.6 Abnormal shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
3.7 Head injury, spinal injury	<input type="checkbox"/>	<input type="checkbox"/>
3.8 Seizures, fits, convulsions, epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
3.9 Blackouts, fainting	<input type="checkbox"/>	<input type="checkbox"/>
3.10 Stroke	<input type="checkbox"/>	<input type="checkbox"/>
3.11 Dizziness, vertigo, problems with balance	<input type="checkbox"/>	<input type="checkbox"/>
3.12 Double vision, difficulty seeing	<input type="checkbox"/>	<input type="checkbox"/>
3.13 Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
3.14 Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
3.15 Neck, back or limb disorders	<input type="checkbox"/>	<input type="checkbox"/>
3.16 Hearing loss or deafness or had an ear operation or use a hearing aid	<input type="checkbox"/>	<input type="checkbox"/>
3.17 Do you have difficulty hearing people on the telephone (including use of hearing aid if worn)?	<input type="checkbox"/>	<input type="checkbox"/>
3.18 Have you ever had, or been told by a doctor that you had a psychiatric illness, or nervous disorder	<input type="checkbox"/>	<input type="checkbox"/>
3.19 Have you ever had any other serious injury, illness, operation, or been in hospital for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
4.1 Have you ever had, or been told by a doctor that you had a sleep disorder, sleep apnoea, or narcolepsy?	<input type="checkbox"/>	<input type="checkbox"/>
4.2 Has anyone noticed that your breathing stops or is disrupted by episodes of choking during your sleep?	<input type="checkbox"/>	<input type="checkbox"/>
4.3 How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently try to work out how they would have affected you.		

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.

Situation	Chance of dozing (0-3)
Sitting and reading	<input type="text"/>
Watching TV	<input type="text"/>
Sitting, inactive in a public place (e.g. a theatre or meeting)	<input type="text"/>
As a passenger in a car for an hour without a break	<input type="text"/>
Lying down to rest in the afternoon when circumstances permit	<input type="text"/>
Sitting and talking to someone	<input type="text"/>
Sitting quietly after a lunch without alcohol	<input type="text"/>
In a car, while stopped for a few minutes in the traffic	<input type="text"/>

5. Please circle the answer that is correct for you:

5.1 How often do you have a drink containing alcohol?
Never Monthly Two to four Two to Three Four or more
or less times a month times a week times a week

5.2 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

5.3 How often do you have six or more drinks on one occasion?
Never Less than Monthly Weekly Daily or
monthly almost daily

5.4 How often during the least year have you found that you were not able to stop drinking once you had started?
Never Less than Monthly Weekly Daily or
monthly almost daily

5.5 How often during the last year have you failed to do what was normally expected from you because of drinking?
Never Less than Monthly Weekly Daily or
monthly almost daily

5.6 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 Weekly Daily or
monthly almost daily

5.7 How often during the last year have you had a feeling of guilt or remorse after drinking?
Never Less than Monthly Weekly Daily or
monthly almost daily

5.8 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 Weekly Daily or
monthly almost daily

5.9 Have you or someone else been injured as a result of your drinking?
No Yes, but not in Yes, during
the last year the last year

5.10 Has a relative or friend, or doctor or other health worker been concerned about your drinking or suggested you cut down?
No Yes, but not in Yes, during
the last year the last year

(Scoring of the AUDIT questionnaire is shown in the section on Alcohol page 31).

	No	Yes
6. Do you use illicit drugs?	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you use any drugs or medications not prescribed for you by a doctor?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you been in a vehicle crash since your last licence examination? If Yes, please give details: _____ _____	<input type="checkbox"/>	<input type="checkbox"/>

Applicant's Declaration (in presence of doctor):

(Print name)

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

Signature: _____ Date: ____/____/____

IMPORTANT
For privacy reasons, the completed Patient Questionnaire must not be returned to the Registrar of Motor Vehicles. Medical information relevant to driver licensing should be included on the Medical Certificate treatment.

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 System:

1.1 Blood Pressure (repeat if necessary)

Systolic mm Hg mm Hg

Diastolic mm Hg mm Hg

1.2 Pulse Rate:

Regular Irregular

1.3 Heart Sounds:

Normal Abnormal

1.4 Peripheral Pulses:

Normal Abnormal

5. Vision:

5.1 Visual Acuity

Uncorrected		Corrected	
R	L	R	L
6/	6/	6/	6/

Are contact lenses worn? No Yes

5.2. Visual Fields (Confrontation to each eye):

Normal Abnormal

2. Chest/Lungs:

Normal Abnormal

6. Hearing: (Commercial Drivers only)

Normal Abnormal

3. Abdomen (liver):

Normal Abnormal

7. Urinalysis:

7.1 Protein: Normal Abnormal

7.2 Glucose: Normal Abnormal

4. Neurological/Locomotor

4.1 Cervical spine rotation

Normal Abnormal

4.2 Back movement

Normal Abnormal

4.3 Upper Limbs

(a) Appearance Normal Abnormal

(b) Joint movements Normal Abnormal

4.4 Lower Limbs

(a) Appearance Normal Abnormal

(b) Joint movements Normal Abnormal

4.5 Reflexes

Normal Abnormal

4.6 Romberg's sign

(A pass requires the ability to maintain balance while standing with shoes off, feet together side by side, eyes closed and arms by sides, for thirty seconds):

Normal Abnormal

8. Neuropsychological Assessment: Where clinically indicated apply the Mini Mental State Questionnaire or General Health Questionnaire or equivalent.

Score:

RELEVANT CLINICAL FINDINGS

Note comments on any relevant findings detected in the questionnaire or examination, making reference to the requirements of the standards outlined in the AFTD publication.

IMPORTANT: For privacy reasons the completed Examination Proforma must not be returned to the Driver Licensing Authority. Medical information relevant to driver licensing should be included on the Medical Certificate (in the case of Driver Licensing Authority initiated examinations) or on the Medical Condition Notification Form (for assessments made in the course of patient treatment).

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