**CARDIOLOGY MEDICAL REPORT**
P-142C REV. 4-2011

STATE OF CONNECTICUT
**DEPARTMENT OF MOTOR VEHICLES**
*DRIVER SERVICES DIVISION*
ct.gov/dmv

**DRIVER'S LICENSE NUMBER**

CDL/PS ☐ YES ☐ NO

**MAIL TO: DMV, Driver Services Division, 60 State Street, Wethersfield, CT 06161-2510**

The patient named below has been referred to the DMV Driver Services Division concerning their ability to safely operate a motor vehicle. This medical report must reflect the results of the medical professional's (licensed physician, PA or APRN) personal examination of the patient performed within 90 days of this report being filed. It must be signed by the patient authorizing the medical professional to release this report and any attachments to DMV.

Address incident of

I hereby authorize the medical professional completing and signing this medical report to release such report to DMV along with any other medical information necessary to determine my fitness to safely operate a motor vehicle.

**PATIENT'S SIGNATURE** X

**DATE**

**PATIENT'S NAME** *(Please Print)* *(Last)* *(First)* *(Initial)*

**DATE OF BIRTH**

**TELEPHONE NUMBER** ( )

**PATIENT'S ADDRESS** *(Street)* *(City)* *(State)* *(Zip Code)*

**HOW LONG HAVE YOU BEEN TREATING THIS PATIENT?**

**DATE OF LAST EXAMINATION**

**CONDITION(S) RELEVANT TO SAFE OPERATION OF A MOTOR VEHICLE**

**TECHNICAL REPORT(S) (*e.g.*, ECHO, SCAN, HOLTER, EKG, CATH) WITH FINDINGS RELEVANT TO OPERATING A MOTOR VEHICLE SAFELY:**

| DATE | TEST | RESULT |
|---|---|---|
| **1.** | | |
| **2.** | | |
| **3.** | | |

LAST EPISODE OF ALTERED CIRCULATORY STABILITY SUFFICIENT TO INTERFERE WITH OPERATING A MOTOR VEHICLE SAFELY.

**DATE**

**TYPE**

MEDICATIONS (RELEVANT TO MOTOR VEHICLE OPERATION)

| NAME OF MEDICATION | DOSE |
|---|---|
| | |
| | |
| | |

**ABNORMALITIES ON CARDIAC EXAMINATION:**

**DO YOU BELIEVE THIS PATIENT UNDERSTANDS THE RISK POSED BY HIS/HER CONDITION(S) WHICH MAY AFFECT HIS/HER ABILITY TO SAFELY OPERATE A MOTOR VEHICLE?** ☐ **YES** ☐ **NO**

**DO YOU BELIEVE THIS PATIENT TAKES MEDICATION AS PRESCRIBED?** ☐ **YES** ☐ **NO** ☐ **NOT APPLICABLE**

**DO YOU HAVE REASON TO SUSPECT THIS PATIENT ABUSES ALCOHOL OR MEDICATIONS (INCLUDING ILLICIT DRUGS)?** ☐ **YES** ☐ **NO**

**CONSIDERING THIS PATIENT'S CONDITION(S), DO YOU BELIEVE THIS PERSON MAY SAFELY OPERATE A MOTOR VEHICLE?** ☐ **YES** ☐ **NO**

**CONSIDERING THIS PATIENT'S CONDITION(S), DO YOU BELIEVE THIS PERSON SHOULD BE ROAD TESTED AND/OR EVALUATED FOR SPECIAL EQUIPMENT REQUIREMENTS?** ☐ **YES** ☐ **NO**

DMV MAY ISSUE A LICENSE SUBJECT TO PERIODIC STATUS REPORTS CONCERNING ANY CHANGES IN CONDITION(S). DOES THIS CONDITION WARRANT PERIODIC REPORTING?

☐ **YES** ☐ **NO** IF YES, PLEASE INDICATE THE CONDITION(S) AND RECOMMEND MONITORING INTERVAL(S):

CONDITION EVERY MONTHS FOR YEAR(S)

CONDITION EVERY MONTHS FOR YEAR(S)

**ARE THERE ANY CONDITION(S) THAT SHOULD BE EVALUATED BY ANOTHER SPECIALIST? PLEASE EXPLAIN:**

**ADDITIONAL COMMENT(S):**

**MEDICAL PROFESSIONAL CERTIFICATION:** I certify that I have personally examined the above named person within the 90 days preceding completion of this report. I swear or affirm under penalty of false statement in accordance with Connecticut General Statutes §14-110 and §53a-157b, and subject to penalties for perjury for a deliberate false statement, that the above information and any attachment hereto is true and correct.

**MEDICAL PROFESSIONAL'S NAME** *(Please print or type)*

**OFFICE ADDRESS** *(Include Zip Code)*

**TELEPHONE NUMBER** ( )

**MEDICAL PROFESSIONAL'S LICENSE NUMBER**

**MEDICAL PROFESSIONAL'S SPECIALTY**

**MEDICAL PROFESSIONAL'S SIGNATURE** X

**DATE REPORT COMPLETED**