PSYCHIATRIC/SUBSTANCE ABUSE MEDICAL REPORT

P-142P/S 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)*

DATE OF BIRTH

TELEPHONE NUMBER ( )

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

DATE OF LAST EXAMINATION

CATEGORY OF MEDICATIONS

☐ **ANTIDEPRESSANTS** ☐ **ANXIOLYTICS** ☐ **MOOD STABILIZERS** ☐ **METHADONE**
☐ **NEUROLYTICS** ☐ **SEDATIVES** ☐ **ANTABUSE** ☐ **NALTREXAN** *(Trexan)*

MEDICATIONS (RELEVANT TO MOTOR VEHICLE OPERATION)

NAME OF MEDICATION	DOSE
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DOES PATIENT CURRENTLY SUFFER FROM CONVULSIVE SEIZURES? ☐ **YES** ☐ **NO**

DATE OF LAST EPISODE — **MONTH** | **YEAR** | **TYPE**

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 PERSON TAKES MEDICATIONS AS PRESCRIBED? ☐ **YES** ☐ **NO**

DO YOU HAVE REASON TO SUSPECT THE PATIENT ABUSES ALCOHOL, MEDICATIONS, OR ILLICIT DRUGS? ☐ **YES** ☐ **NO** **IF YES,** *(Please elaborate)*

DMV MAY ISSUE A LICENSE SUBJECT TO PERIODIC STATUS REPORTS CONCERNING ANY CHANGES IN CONDITION(S). DOES THIS CONDITION WARRANT PERIODIC MEDICAL 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 OTHER CONDITION(S) THAT SHOULD BE EVALUATED BY ANOTHER SPECIALIST? ☐ **YES** ☐ **NO** *(Please Explain)*

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

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

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