Motor Vehicle Administration
6601 Ritchie Highway, N.E.
Glen Burnie, Maryland 21062

DC-119 (03-10)

# Driver Wellness and Safety Division - Physician/Healthcare Provider Report

**For Office Use Only: Requested By:** _____ **Date Requested:** _____

**TO THE DRIVER/APPLICANT: Please completed Section 1 below.**

If information is filled in by the MVA, please check to see if it is accurate and make corrections. Your physician/healthcare provider completes the rest of this report. It should be returned to the MVA along with other forms that may have been sent with the cover letter that accompanied this form. Your physician/healthcare provider may choose to submit this report directly to the MVA. (Please note: Payment for any examination and preparation of this form is YOUR responsibility.)

Per Maryland Vehicle Law Transportation Article, §16-118, all medical information obtained will be kept CONFIDENTIAL and used to determine "the qualifications of an individual to drive." In some cases, "The Administration may use information in its records for the purpose of driver safety research, provided that personal information is not published or disclosed."

## SECTION 1: GENERAL INFORMATION (To be completed by driver/applicant)

(Please Type or Print)
DRIVER/APPLICANT'S NAME: _____
(LAST) (FIRST) (MIDDLE)

ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP)

DATE OF BIRTH: _____ PHONE NUMBER(S): _____
(MONTH/DAY/YEAR)

DRIVER'S
LICENSE NUMBER: _____ _____ _____ _____ _____

## PHYSICIAN/HEALTHCARE PROVIDER COMPLETES SECTIONS #2 – #7

**TO THE PHYSICIAN/HEALTHCARE PROVIDER:**

Your patient has self-reported a medical condition that may impact her/his fitness to drive safely OR has been referred to the MVA because of a concern. There may be MVA notes below about this client and/or a request for specific information.

Please complete sections 2-7 of this form and give it to your patient for return to the MVA, OR, return the form by mail or fax to:

**Maryland MVA; Division of Driver Wellness & Safety**
**6601 Ritchie Highway, NE – Room 124; Glen Burnie, MD 21062**
**Driver Wellness & Safety Fax Number 410-768-7627**
**Questions? Please call: 410-768-7511**

**MVA Notes to Physician/Healthcare Provider** _____

_____

_____

_____

## SECTION 2: HISTORY

**In the past two years**

1. Has your patient been in any vehicle crashes/accidents? Yes ____ No ____ Unk ____

   1a. If YES, when? _____

2. Has your patient expressed any concern(s) about their medical fitness to drive? Yes ____ No ____ Unk ____

   If YES, please explain: _____

3. Has your patient had any of the following?

   Loss of Consciousness (LOC) _____ Seizure _____ Syncope _____

   Any LOC/altered state of consciousness requiring assistance _____

   If YES, what was the date of the last episode? _____

4. Has your patient sustained a fall? Yes ____ No ____ Unk ____

5. Have you treated this patient or referred him/her to another clinician for any of the following conditions that could affect driving? (Please use comment section to provide information.)

| | | | Date |
|---|---|---|---|
| a. | Diabetes requring insulin | Yes ____ | _____ |
| b. | Seizure/epilepsy | Yes ____ | _____ |
| c. | Multiple sclerosis | Yes ____ | _____ |
| d. | Cardiac condition | Yes ____ | _____ |
| e. | CVA or transient ischemic attack | Yes ____ | _____ |
| f. | Alcohol or drug abuse/dependence | Yes ____ | _____ |
| g. | Traumatic brain injury | Yes ____ | _____ |
| h. | Loss of limb or limbs | Yes ____ | _____ |
| i. | Bipolar disorder | Yes ____ | _____ |
| j. | Schizophrenic disorder | Yes ____ | _____ |
| k. | Panic disorder | Yes ____ | _____ |
| l. | Visual problem | Yes ____ | _____ |
| m. | Parkinson's disease | Yes ____ | _____ |
| n. | Dementia/possible cognitive problem | Yes ____ | _____ |
| o. | Sleep disorder (ex: narcolepsy, sleep apnea) | Yes ____ | _____ |
| p. | Autism | Yes ____ | _____ |
| q. | Any other condition(s) that impact safe driving | Yes ____ | _____ |

Comment(s): _____

_____

_____

## SECTION 3: CURRENT DIAGNOSES AND MEDICATIONS

| LIST CURRENT DIAGNOSES | CURRENT MEDICATIONS |
|---|---|
| 1. | 1. |
| 2. | 2. |
| 3. | 3. |
| 4. | 4. |
| 5. | 5. |
| 6. | 6. |

## SECTION 4: DIAGNOSTIC STUDIES

Please provide results of diagnostic studies (laboratory, imaging, etc.) that are pertinent to conditions that can affect your patient's fitness to drive.

_____

_____

_____

_____

## SECTION 5: PHYSICAL, COGNITIVE, MENTAL HEALTH STATUS

Does your patient have any cognitive, physical, or mental health problems that affect her/his ability to safely operate a motor vehicle?

Yes ☐ No ☐ Not Sure ☐

If YES or NOT SURE, please explain:

_____

_____

_____

Does your patient require any of the following?

cane ☐ walker ☐ wheelchair ☐ scooter ☐ portable oxygen ☐

adaptive equipment to drive ☐ other _____

## SECTION 6: FITNESS TO DRIVE SUMMARY

1. For the conditions listed in Section 3, to your knowledge is your patient compliant with the treatment plan, including taking of medications and office appointments? Are the conditions stable and/or improving? If your answer is "no" to either of these questions, please elaborate.

_____

_____

_____

2. Based on your evaluation of this patient, do you have any concern about his/her ability to safely operate a motor vehicle? Yes _____ No _____ Not Sure _____

3. If YES, or NOT SURE, please explain _____

_____

_____

4. Do you think any additional assessment would help to determine your patient's medical fitness to drive?

   Yes _____ No _____

   If YES, please explain _____

   _____

## SECTION 7: PHYSICIAN/HEALTHCARE PROVIDER ATTESTATION

1. How long has this patient been under your care? _____
2. What was the date of her/his last visit? _____
3. Name of Physician/Healthcare Provider _____
   (Print, type or use stamp)
4. License Number _____ 5. Specialty _____
6. Address _____
7. Phone number _____ 8. Fax number _____
9. Signature _____ 10. Date _____