TIM TIPTON
COMMISSIONER

J. KEVIN STITT
GOVERNOR

STATE OF OKLAHOMA
DEPARTMENT OF PUBLIC SAFETY

Dear Medical Professional:

The bearer of this medical examination form has been requested to undergo a medical examination by a licensed physician or appropriate medical professional. **The completion of this form must be based on an examination performed within the last sixty (60) days.**

THE APPLICANT WILL BE RESPONSIBLE FOR ANY PROFESSIONAL FEE CHARGED FOR THE EXAMINATION.

This medical examination is required under one or more of the following categories:

(1) All original applicants who have known medical conditions which may affect their driving ability.

(2) Any driver who indicates to an investigating officer at the scene of an accident that he/shedid not know the cause of the accident because of a "blackout" or seizure.

(3) All licensed drivers who have physical impairments which mayaffect their driving ability.

(4) Any person reported by a verifiable source as having questionable physical or mental capacities to safely operate a motor vehicle.

Respectfully,

MEDICAL STANDARDS SECTION
DEPARTMENT OF PUBLIC SAFETY

AUTHORIZATION AGREEMENT

This medical examination authorization agreement must be completed and signed by the applicant to allow the Department of Public Safety to review the medical information for driver license purposes.

* * * * * * * * *

I hereby authorize the following physician(s) who may have attended me and/or the hospital(s) or clinic(s) in which I may have been treated, to give the Department of Public Safety any information theymay request concerning my condition.

PHYSICIAN	HOSPITAL OR CLINIC
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I understand that this authorization includes permission for the Department of Public Safety to have this information reviewed by the Oklahoma Driver License Medical Advisory Committee for the purpose of giving the Department a medical opinion on my case for guidance in determining my physical or mental capabilities to operate a motor vehicle safely, in the interest of the general public.

DATE	SIGNATURE OF LICENSEE/APPLICANT

PRINT FULL LEGAL NAME_____

MAILING ADDRESS_____ City ST, ZIP_____

DOB_____ DL#_____

PHYSICAL DESCRIPTION: Height_____Weight _____

1. ORTHOPEDIC AND NEUROMUSCULAR

A.	Spastic or ankylose joints?	Yes _____	No _____
B.	Joint Ataxia, Paralysis, or Weakness?	Yes _____	No _____
C.	Amputations?	Yes _____	No _____
D.	Type and date: _____		
E.	Prosthetic devices used?	Yes _____	No _____
F.	Do these compensate for driving tasks?	Yes _____	No _____
G.	Are additional prosthetic devices needed?	Yes _____	No _____
H.	Other orthopedic deformities?	Yes _____	No _____
I.	If yes, describe:		
J.	Peripheral Neuropathy	Yes _____	No _____
K.	limitations due to PN, describe _____		
L.	Stenosis, (spinal)	Yes _____	No _____
M.	Loss of function/sensation		

2. CARDIOVASCULAR BP_____ Pulse_____

Does the patient have a history of cardiovascular disease involving: Stokes-Adams Syndrome, Arrhythmia, Syncopal episodes, Carotid Sinus Sensitivity, Vertigo, Angina Pectoris, Myocardial Infarction, CHF, or Coronary Insufficiency? (List those applicable)

_____

Is it severe enough, in your opinion, to impair this person's functional capabilities to safely operate a motor vehicle? Yes _____ No _____

3. DIABETES

Is the patient a known diabetic? Yes _____No _____If yes, date of onset_____

A.	Status of Control/A1C hemoglobin results:_____		
B.	Insulin use?	Yes _____	No _____
C.	Other anti-diabetic drugs?	Yes _____	No _____
D.	Diabetic Acidosis?	Yes _____	No _____
E.	Insulin Reactions?	Yes _____	No _____
F.	Date of last insulin reaction. _____		
G.	Did this reaction result in loss of consciousness or hospitalization?	Yes _____	No _____

4. HYPOGLYCEMIA

A. Is the patient hypoglycemic? Yes _____ No _____

Date of Onset: _____ Status of control:_____

B. Has the patient had lapse, loss or alteration of consciousness as a result? Yes _____No _____

If yes, give date and description: _____

_____

5. **VISION** (ONLY IF SPECIFICALLY REQUESTED - UNDER SEPARATE COVER)

A. Visual acuity:

RE 20/_____ LE 20/_____ ❒ Without corrective lenses ❒ With corrective lenses

B. Visual field with one or both eyes (in degrees):

Right of Center_____Left of Center_____Method: _____

C. If disease or injury is present, give the diagnosis: _____

D. Is further examination by a vision specialist recommended at this time? Yes _____ No _____

6. **HEARING**

A. Is the patient deaf or wearing hearing aids? Yes _____ No _____

B. Does the patient have a hearing deficiency? Yes _____ No _____

7. **DRUGS AND ALCOHOL**

A. Is there any evidence or personal knowledge of substance abuse or addiction to drugs or alcohol? Yes _____ No _____

If yes, give a brief history of substance usage and/or treatment: _____

_____

8. **PSYCHOLOGICAL / *COGNITIVE* / *DEMENTIA* / *ALZHEIMER'S* ASSESSMENT**

A. Does this person have a diagnosed mental disorder or is there any evidence of tension, tremulousness, anxiety, depression, hostility, bizarre behavior, paranoia, suicidal tendencies, impairment of judgment, confusion, hallucinations, or delusions?
Yes _____No _____

If yes, please explain:_____

_____

B. Is further psychological evaluation suggested at this time? Yes _____ No _____

9. **SYNCOPE**

A. Give a date and description of the most recent lapse, loss, or alteration of consciousness:

_____

B. Cause or diagnosis: _____

_____

C. Prognosis: _____

10. EPILEPSY/SEIZURE DISORDER

A. Do you know or suspect this patient has a seizure disorder? Yes _____ No _____

Type of seizures:_____ Date of onset: _____

Number of episodes *within the last six (6) months*: _____

Date, description, and cause (if known) of last episode resulting in lapse, loss, or alteration of consciousness: _____

_____

B. Is this person currently being treated by a neurologist?Yes _____ No _____
[If yes, additional information from a neurologist may be requested]

C. If no longer on anti-convulsant medication, when was it discontinued? _____

11. OTHER NEUROLOGICAL/NEUROMUSCULAR DISORDER

A. Does this person have a limiting or progressive neurological/neuromuscular deficit?
Yes _____ No _____

B. Diagnosis: _____

C. Description of limitation: _____

D. How would the condition affect his/her ability to control a motor vehicle? _____

_____

E. Is the condition progressive? Yes _____ No _____

12. OTHER CONDITIONS

List any other significant medical conditions not previously addressed:

_____

_____

_____

13. MEDICATION AND DOSAGE CURRENTLY PRESCRIBED FOR THIS PATIENT. *Medication(s) must be listed, or the report will be returned*.

_____ _____

_____ _____

_____ _____

_____ _____

14. HOW LONG HAVE YOU BEEN TREATING THIS PATIENT? _____

Has the patient been reliable in taking necessary medications and reporting for scheduled appointments? Yes _____ No _____

15. IN YOUR MEDICAL OPINION, IS THIS PATIENT'S CONDITION CONTROLLED? Yes _____ No _____

Length of current stable period: _____

If not under control, please explain: _____

_____

16. WOULD YOU RECOMMEND THAT THE DEPARTMENT RETEST THIS PERSON'S DRIVING ABILITY?

Yes _____ No ____

Any additional comments you would like to be taken under consideration? _____

_____

17. IN YOUR PROFESSIONAL OPINION, FROM A MEDICAL STANDPOINT, IS THIS PERSON PHYSICALLY AND MENTALLY CAPABLE OF SAFELY OPERATING A MOTOR VEHICLE?

Yes _____ No _____

COMMENTS: _____

DATE OF EXAMINATION_____

_____
PRINT NAME OF PHYSICIAN

_____
SIGNATURE OF PHYSICIAN

_____
LICENSE # AND STATE OF

_____
SPECIALTY

_____
STREET ADDRESS

_____
CITY, STATE AND ZIP

(_____)_____
TELEPHONE

The medical professional must submit the completed form.

Please mail forms directly to

Medical Standards Section
Department of Public Safety
PO Box 53004
Oklahoma City, OK 73152-9998

Or fax the completed form to 405-497-7035