

Given names

Surname

Date of Birth

day / month / year

Gender

Male

Female

Driver licence number

Residential address (*PO box not accepted*)

Postcode

Contact phone number

Email address

INFORMATION FOR HEALTH PROFESSIONALS

The information provided by your medical practitioner is important in deciding whether you meet the commercial medical standards for the purpose of driving public passenger vehicles and for the purpose of whether to grant, renew, suspend or cancel your driver licence or impose a condition on it.

Please return this form to Licence Review Unit

Locked Bag 14

Grafton NSW 2460

Email: DA.Medicals@rms.nsw.gov.au

INFORMATION FOR THE APPLICANT

The information provided by your medical practitioner is important in deciding whether you meet the commercial medical standards for the purpose of driving public passenger vehicles and for the purpose of whether to grant, renew, suspend or cancel your driver licence or impose a condition on it.

Privacy Statement

Your personal and health information collected in this form will be held by Roads and Maritime at 20-44 Ennis Road, Milsons Point NSW 2061. You may request access to and / or correction of this information. Your personal and health information is being collected and will be retained and used for the purpose of verifying your fitness to drive and to hold a driver licence or Public Passenger Vehicle Driver Authority. You are required to provide this information under Road Transport and Passenger Transport legislation. Failure to do so may result in your driver licence or Public Passenger Vehicle Driver Authority being refused, suspended or cancelled. The health information which Roads and Maritime, collects may be used to determine your medical fitness to hold a driver licence or Public Passenger Vehicle Driver Authority, and if you hold a Mobility Parking Scheme permit (MPS permit) to determine your eligibility to hold an MPS permit. Your personal and health information held by Roads and Maritime may be disclosed in order to verify it to any medical practitioner in respect of ascertaining or reviewing your fitness to drive or to hold a driver licence, in respect of a motor accident or other litigation enquiries and to other Public Passenger Vehicle transport regulators, driver licensing and vehicle registration agencies. If your application relates to a Public Passenger Vehicle Driver Authority we may also disclose your personal information or health information where relevant to accredited operators, networks, booking or rideshare service providers under the *Passenger Transport Act 2014* (or other related legislation) and also to Transport for NSW in connection with the administration of any such legislation. Otherwise it will not be disclosed unless permitted by law.

Roles and Responsibilities of the driver

Legislation requires a driver to advise Roads and Maritime of any long-term injury or illness that may affect his or her safe driving ability. These laws may impose penalties for failure to report. As well as these legal obligations, a driver may be liable at common law if he or she continues to drive knowing that he or she has a condition that is likely to adversely affect safe driving.



NSW Fitness to Drive Medical Assessment Commercial Standards

Sections 1, 2 and 3 must be completed for ALL patients. If the patient has a vision, eye disorder or a visual field defect an optometrist or ophthalmologist must complete these sections. Complete all other sections, indicating medical conditions where appropriate.

1. Does the patient have a vision or eye disorder? Yes No

If Yes, please tick the condition(s). Refer to part B:10 of Assessing Fitness to Drive, pg 128-130.

- Cataracts Diplopia/Double vision Glaucoma
- Monocular vision Poor night vision Macular degeneration

Other, specify: _____

Tick if the condition(s) indicated above is corrected by wearing glasses or contacts. Refer to part B:10 Figure 15, pg 125.

2. What is the patient's visual acuity? Right Left Together

List Visual Acuity uncorrected 6/____ 6/____ 6/____

List Visual Acuity with glasses/contacts 6/____ 6/____ 6/____

3. Does the patient have a restricted visual field or a visual field defect? Refer to part B:10-10.2.2, pg 125. Yes No

List visual fields in degrees: _____

Tick if the binocular visual fields do not meet the standards

Optometrist or ophthalmologist details. Complete only if relevant:

Name: _____ Date: _____

Signature: _____ Tel No: _____

4. Does the patient have a cardiovascular condition(s)? Yes No

If Yes, please tick the condition(s). Refer to part B:2, pg 45-57.

- Acute Myocardial Infarct Aneurysms (abdominal & thoracic)* Angina Angioplasty
- Cardiac Arrest Cardiac Defibrillator (ICD)** CABG Congenital Disorders
- Dilated Cardiomyopathy HCM Cardiomyopathy Heart Transplant Heart Failure
- Pacemaker Other (Refer to part B:2, pg 53-57): _____

*Specify size of Aneurysm: _____

Tick if repaired and does not impact driving ability

**All patients with an ICD implant require periodic specialists referral and cannot hold a commercial licence. Refer to part B:2, pg 50.

5. Does the patient have diabetes? Yes No

If Yes, indicate the medication. Refer to part B:3, pg 63-65.

Insulin Tablets/other non insulin agents

Tick if patient is not compliant with medication

Specify any end organ effects: _____

6. Does the patient have epilepsy? Refer to part B:6, pg 89-94. Yes No

If Yes, specify _____ Date of last two seizures: (a) _____ (b) _____

Tick if the diagnosis is confirmed by a specialist Date medication ceased, if applicable: _____

7. Does the patient have Dementia or other cognitive impairment? Refer to part B:6, pg 80. Yes No

Specify: _____

Tick if specialist referral is required. Refer to part B:6-6.1.2, pg 77.

8. Does the patient have a neuromuscular condition? Refer to part B:6, pg 103. Yes No

Specify: _____

Tick if specialist referral is required

Tick if driving assessment is required

9. Does the patient have vestibular, neurological or other neurodevelopmental disorders? Yes No

If Yes, tick the condition(s). Refer to part B:6, pg 100-105.

- Aneurysms (unruptured intracranial) Blackout: Date of most recent episode: _____
- Brain tumour(s) Cerebral Palsy Head/Brain Injury Intellectual impairment
- Meniere's Disease Multiple Sclerosis Parkinson's Vertigo
- Stroke: Date of most recent episode*: _____ Syncope: Date of most recent episode: _____
- Other specify: _____

*If within the last 12 months specialist referral is required.

10. Does the patient have sleep apnoea or narcolepsy?

Yes No

If Yes, tick the condition(s). Refer to part B:8, pg 115.

- Narcolepsy Tick if not well controlled. All patients with Narcolepsy must see a specialist.
 Sleep Apnoea Tick if not well controlled. Refer all commercial drivers with sleep apnoea to a specialist.

11. Does the patient have mental health issues?

Yes No

If Yes, tick the condition(s). Refer to part B:7, pg 110. Refer to part B:7-7.2, pg 108-109 for general assessment guidelines.

- Anxiety disorder ADHD Bipolar affective disorder Chronic depression
 Personality disorder PTSD Schizophrenia Tourettes
 Other, specify: _____
 Tick if the patient requires medication for any of the above conditions
 Tick to confirm if the patient is not compliant with medication
 Tick if the condition is of such severity that it requires a psychiatric review

12. Does the patient have a musculoskeletal disorder?

Yes No

If Yes, tick the condition(s). Refer to part B:5, pg 74.

- Chronic pain Deformities Loss of digits Loss of limbs Severe arthritis Other
 Specify condition: _____
 Tick if the patient requires vehicle modifications
 Tick if the Roads and Maritime practical driving test is required
 Tick if an occupational therapist driving assessment is required

13. Is the patient dependant on drugs or alcohol (eg based on ICD-10 criteria)?

Yes No

If Yes, refer to part B:9, pg 120-121.

- Tick if the patients' alcohol use disorder is likely to affect safe driving. Specify: _____
 Tick if the patient's illicit drug use is likely to affect safe driving. Specify: _____
 Tick if the patient is in a treatment program
 Tick if patient requires specialist referral
Specify any end organ damage that could affect driving: _____

14. Is the patient taking multiple medications that may affect driving?* Refer to part A:2-2.8, pg 11-12.

Yes No

If Yes, specify effects on driving _____ *Please refer the patient for a Home Medicine Review, if appropriate

15. Does the patient have severe hearing loss? For commercial drivers only. Refer to part B:4, pg 68-69.

Yes No

APPLICANT'S DECLARATION AND CONSENT

This section must be completed

I declare I have provided true and complete details to my medical practitioner. I consent to my medical practitioner providing my health information to Roads and Maritime, or to a medical practitioner nominated by Roads and Maritime. Further, I give authority to Roads and Maritime to obtain details of any matter which may assist in determining whether I meet the medical criteria outlined in the publication 'Assessing Fitness to Drive' (Commercial and Private Vehicle Drivers) 2016 or, if applying for a Public Passenger Vehicle Driver Authority, under the *Passenger Transport Act 2014*.

Signature: _____ Date: _____

Doctor or Medical Specialist's Certification

How long have you treated the patient? *List years / months* _____ Y _____ M

How long has the patient been with this practice? *List years / months* _____ Y _____ M

Did you have knowledge of the patients medical history before undertaking this assessment? *Refer to part A:3-3.3.4, pg 18. If you ticked no, request the patient's medical file from their regular practitioner and/or conduct a more thorough examination than usual to ensure they meet the Assessing Fitness To Drive medical standards* Yes No

Any additional comments on conditions likely to affect driving? *If Yes, attach supplementary documents* Yes No

This assessment has been undertaken in accordance with the commercial medical standards as set out in the 'Assessing Fitness to Drive' (Commercial and Private Vehicle Drivers) 2016

In my opinion, the patient of this assessment: *Tick one option. Refer to part A:4-4.4. pg 22.*

- Option 1:** Meets the medical criteria for an unconditional licence
- Option 2:** Meets the medical criteria for an unconditional licence and requires annual medical assessment (drivers 75+)
- Option 3:** Meets the medical criteria subject to further assessment (practical driving test or specialist medical review)
- Option 4:** Meets the medical criteria for a conditional licence, subject to periodic medical review (indicate restrictions below if appropriate)
- Option 5:** Does not meet the medical criteria for an unconditional or conditional driver licence

If Option 3 ticked: Which assessment is recommended? Tick requirements.

- Roads & Maritime practical driving test
- Occupational therapist driving assessment
- Review by a specialist. *Specify:* _____

If Option 4 ticked: What are the recommended licence conditions? Tick all that is relevant. Refer to part A:4, pg 23-24.

- Downgrade to a lower class of licence. *Specify:* _____
- Daylight hours only
- Modified vehicle. *Specify:* _____
- Radius restriction. *Specify distance:*
- 2km 5km 10km 15km 20km 30km 40km 50km 75km 100km
- Extension of the Alcohol Interlock Program (for a patient currently on the Program)

Date: _____

Doctor's name: _____ Signature: _____

Field of Practice: _____

Address: _____

Tel No: _____ Fax No: _____ Email (optional): _____

Office Use Only

CSO Name and Signature, Staff Number, SNSW Service Centre stamp and date

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Refer to Licence Review Unit