

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/she did not know the cause of the accident because of a "blackout" or seizure.
- (3) All licensed drivers who have physical impairments which may affect 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 they may 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. *Only list medications directly related to ailments identified within this report.*

_____	_____
_____	_____
_____	_____
_____	_____

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 submit the completed form to:

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

By email: medicaldesk@dps.ok.gov