Driver Medical Evaluation

P.O. Box 201430, Helena, MT 59620-1430 ● Phone (406) 444-3933 ● Fax (406) 444-1631 ● www.dojmt.gov ● DriverLicense@mt.gov

Please PRINT

Legal **Last** Name	Legal **First** Name	**Driver License** Number	
Mailing Address	City	State	Zip
Email Address	**Phone Number**	**Date of Birth**	

A. Introduction to Physician/Provider

The Motor Vehicle Division records indicate your patient may have a condition that could affect the safe operation of a motor vehicle.

Your experience and knowledge of the patient's condition, results of medical examinations and treatment plans, will be of great value in assisting the department to determine a proper licensing decision. A physician reporting in good faith is immune from liability, civil or criminal penalties under Montana law § 37-2-311, M.C.A. and § 37-2-312, M.C.A. The department has sole responsibility for any decision regarding the patient's driving qualifications and licensure. The department will also consider non-medical factors in reaching a decision.

PLEASE ANSWER ALL APPLICABLE QUESTIONS. Leave blank any items not covered in your examination. If the case is unique, additional comments may be helpful. Attach a separate sheet if necessary. **For proper identification, have the patient sign the release authorization in your presence.**

B. Referral Description

We are seeking information about any condition which may interfere with the safe operation of a motor vehicle. The patient presented with: _____

RELEASE OF INFORMATION BY PATIENT – SIGN IN PRESENCE OF PHYSICIAN/PROVIDER

I authorize my physician/provider or hospital to answer any questions from the Motor Vehicle Division, or its employees relating to my physical or mental condition, and/or drug and/or alcohol use or abuse, and to release any related information or records to the Motor Vehicle Division or its employees. Any expense involved is to be charged to me and not the State of Montana.

I authorize the Motor Vehicle Division to receive any information relating to my physical or mental condition, and/or drug and/or alcohol use or abuse, and to use the same in determining whether I have the ability to operate a motor vehicle safely.

Signed: **X** _____ Date: _____

C. History

How long has this person been your patient? | Date of last examination:

Applying for ☐ Class D (Regular driver) ☐ Intrastate CDL (Montana only) ☐ Interstate CDL

D. Medications

List any medication currently prescribed: _____

Is the patient adhering to the medical regimen? ☐ Yes ☐ No If no, explain:

Would the side effects from the prescribed medication interfere with the safe operation of a motor vehicle? ☐ Yes ☐ No
If yes, describe:

Is your patient under a controlled medical program? ☐ Yes ☐ No

Indicate how long control has been maintained (i.e. 3 months, 6 years, etc.)? Months Years

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E. Lapse of Consciousness or Control Disorder

Does your patient exhibit any disease or disorder including epilepsy, narcolepsy, diabetes, cerebral vascular disease, or any other impairment that may cause loss of consciousness or control of motor functions at any time? ☐ Yes ☐ No

Date of last episode: _____ Is condition stabilized? ☐ Yes ☐ No

Describe Condition(s):

F. Impairments

Does your patient have any impairments? (Mark all that apply)

- ☐ Impaired motor function
- ☐ Reaction, or impairment due to change in medication or dosage
- ☐ Neurological or neuromuscular disease
- ☐ Diminished concentration
- ☐ Diminished judgment
- ☐ Memory Loss
- ☐ Alzheimer's disease
- ☐ Confusion
- ☐ Other: _____

Describe Condition(s): _____

G. Diagnosis

Is the condition: ☐ Improving ☐ Stable ☐ Worsening or deteriorating ☐ Subject to change

H. Physical and Mental Capability

Is your patient physically and mentally capable of safely operating a motor vehicle, in your opinion? ☐ Yes ☐ No

If **NO**, describe: _____

I. Adaptive Equipment

Do you recommend any adaptive equipment for your patient? ☐ Yes ☐ No If **Yes**, mark all that apply

- ☐ Steering Knob
- ☐ Pedal Extension
- ☐ Manual Brake
- ☐ Automatic Transmission
- ☐ Mechanical Turn Indicator
- ☐ Hand Controls
- ☐ Other: _____

Describe why adaptive equipment is needed: _____

Note: The Motor Vehicle Division may not be able to add recommended restrictions in certain situations.

20-1900 (3/17)

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J. Driving Restrictions

Do you recommend any driving restrictions for your patient? ☐ Yes ☐ No If **Yes**, mark all that apply

- ☐ Corrective Lenses
- ☐ Low Speed Vehicle Only
- ☐ No Interstate Driving
- ☐ No Inclement Weather
- ☐ Prosthetic Aid Required
- ☐ Left Outside Mirror (for hearing impaired)
- ☐ Restricted Area:
- ☐ Restricted Speeds (45 mph secondary roads, 55 mph interstate)
- ☐ Oxygen While Driving
- ☐ Daylight Hours Only
- ☐ Other: _____

Describe why driving restrictions are needed: _____

K. Periodic Driving Evaluations

Do you recommend the Motor Vehicle Division conduct periodic driving evaluations of your patient? ☐ Yes ☐ No

If **YES**, how often? ☐ 6 months ☐ 1 year ☐ 2 years ☐ ___ years

L. Periodic Knowledge Testing

Do you recommend the Motor Vehicle Division conduct periodic knowledge testing of your patient? ☐ Yes ☐ No

If **YES**, how often? ☐ 6 months ☐ 1 year ☐ 2 years ☐ ___ years

M. Periodic Medical Report

Do you recommend your patient submit a periodic Medical Evaluation to the Motor Vehicle Division to monitor changes? ☐ Yes ☐ No

If **YES**, how often? ☐ 6 months ☐ 1 year ☐ 2 years ☐ ___ years

N. Certification of Physician/Provider

Print Name:	Type of Practice or Medical Specialty:	Medical License Number:
Address:	Email:	Phone Number:
Signature:		Date:

Please return completed form by fax, email, or mail form to:

Motor Vehicle Division
Attn. Medical Unit
P.O. Box 201430
Helena, MT 59620-1430

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