



MEDICAL EXAMINATION REPORT

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Wisconsin Department of Transportation
Medical Review
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Once completed, this form can be faxed, emailed or mailed to us at any of the addresses listed to the right. After we've reviewed this report, you may be required to file medical reports periodically. We will send you the forms at the time they are required.

Applicant Name		Driver License Number				Other Type Behav Board Waiver
Street Address		Birth Date				
City, State ZIP Code		(Area Code) Telephone Number				
Date Report Issued (m/d/yy)	WisDOT Examiner Badge #	License Type	CLP	CDL	Passenger Bus	
		Instruction Permit		Operator	School Bus	

Reason for Referral – Provide a narrative summary of medical condition

HEALTH CARE PROFESSIONAL: Please complete all pertinent sections relative to this person's health to assist the Department in making a licensing decision.

- Driver Condition or Behavior Report** Attached. Driving Incident/Accident Date(s): _____
- General Medical:** complete sections **A** and **G** (others if appropriate)
- Mental/Emotional:** complete sections **A**, **B**, and **G**
- Neurological:** complete sections **A**, **C**, and **G**
- Endocrine: Diabetes, Nephrology, etc.** complete sections **A**, **D**, and **G**
- Cardiovascular:** complete sections **A**, **E**, and **G**
- Pulmonary:** complete sections **A**, **F**, and **G**

SECTION A HEALTH CARE PROFESSIONAL – To Complete for ALL Applicants

Provide Diagnoses, Medications Used, and Dosages (include additional documents, if needed):	Height
	Weight

YES NO

- Is the person's condition currently stable? **If not, explain below.**
- Is the person reliable in following the treatment program? **If not, explain below.**
- Does this person experience side effects of medication which are likely to impair driving ability? **If yes, explain below.**
- Has this person experienced an episode of altered consciousness or loss of bodily control during the past 12 months?
If yes, explain below and give date.
- Does current alcohol/drug abuse/use interfere with medical condition? **If yes, a substance evaluation will be required.**
 - Did the person have a seizure(s) related to withdrawal? **If yes, explain below and give date.**
- Does this person experience uncontrolled sleepiness associated with sleep apnea, narcolepsy, or other disorder?
If yes, explain below.
- Is driving ability likely to be impaired by limitations in any of the following?
 - Judgment and insight
 - Problem-solving and decision-making
 - Emotional or behavioral stability
 - Cognitive function or memory loss
- Is driving ability likely to be impaired by limitations in any of the following?
 - Reaction time
 - Sensorimotor function
 - Strength and endurance
 - Range of motion
 - Maneuvering skills
 - Use of arm(s) and/or leg(s)

Details and Elaboration



SECTION B MENTAL/EMOTIONAL

YES NO

1. Has the person been hospitalized? If yes, please provide us with the following:
 - a. Admission and discharge dates: _____
 - b. Reason for hospitalization and significant findings: _____
 - c. Discharge condition and recommendations for continued care: _____
2. Identify any High Risk Behaviors: _____
3. Identify current treatment program(s), counseling, etc.: _____
 - a. Compliant with treatment? _____
 - b. Any medications that may have an adverse reaction if driving? _____
4. Does the person have any residual effects that could be a safety concern for driving? _____

SECTION C NEUROLOGICAL

Medical Examiner: To be considered for a license, the medical examination must be **at least 60 days after the episode.**
If last episode occurred within the past 90 days, the patient is not eligible to hold a license.

YES NO

1. Did this person have a seizure within the past 90 days?
2. Give date of last episode of altered consciousness or loss of bodily control. **Date:** _____ (m/d/yy)
3. Does this person have a seizure disorder? **If not, explain cause and/or diagnosis related to episode(s).**

4. List anticonvulsant medication: _____. If discontinued, give date: _____
5. Was the last medication blood serum level within acceptable range?
6. Does this person's neurological condition involve movement disorder? If yes, please explain:

7. If this person holds or is applying for a commercial driver license, and has had an episode of altered consciousness or loss of bodily control since the last report was filed with WisDOT, a narrative summary will be required, to include a history of the episode(s), the risks of further episodes, the current blood levels of anticonvulsant medication, results of the most recent EEG.

SECTION D ENDOCRINE: Diabetes, Nephrology, etc.

YES NO

1. Please provide a hemoglobin A₁C reading: _____ (Reading) _____ (Date)
2. Does this person have hypoglycemic reactions requiring assistance?
If yes, please explain frequency and provide date of last reaction: _____
3. Does this person demonstrate how to counter these reactions?
4. Has this person been hospitalized for treatment of diabetes or complications in the past year? If yes, explain below:

5. Indicate type of medication and dosage for current treatment. _____
6. Is this person experiencing renal failure/CKD? Is dialysis required? What is the treatment schedule, if any? What are the residual effects, if any? What type of dialysis? _____
7. Does this person monitor his/her blood sugar?
8. Provide the last 3 fasting blood sugar readings and dates recorded. (Home monitoring results ARE acceptable.)

(Reading) (Date) (Reading) (Date) (Reading) (Date)
9. If this person holds or is applying for a **commercial driver license**, and is taking insulin in the past 2 years, please provide the following information:
 - a. When was this person diagnosed with diabetes? _____
 - b. When was insulin first prescribed? _____
 - c. Is this person currently treated with insulin? _____
 - d. Do any complications or associated conditions exist? If yes, please explain:

 - e. Has patient completed any type of diabetic education? _____



SECTION E CARDIOVASCULAR

1. Functional Class
I II III IV

YES NO

- 2. Does the person have an implantable cardioverter defibrillator? If yes, give implant date: _____
 - a. Has patient been medically cleared by an electrophysiologist for:
 - *motor vehicle (car or motorcycle): Y/N ____
 - *commercial motor vehicle (CDL): Y/N ____
 - *school or passenger bus: Y/N ____
 - b. Name of electrophysiologist: _____
- 3. Has the unit discharged since the implant? If yes, describe the person's condition at the time and date of discharge.

Has this person had any of the following? Please explain any yes answers.

YES NO

- 4. Cardiovascular surgery and/or other procedures. Describe and give date(s): _____

- 5. List all current cardiac symptoms: _____

- 6. Syncope due to cardiovascular condition: _____
- 7. Dyspnea at rest: _____
- 8. Fatigue at rest: _____
- 9. Have any cardiac tests been conducted (exercise stress test, etc.)? **If yes, give procedure(s), date(s), results.**

SECTION F PULMONARY

YES NO

- 1. Pulmonary Disease? If so, what? _____
- 2. Continuous Oxygen Use Required? If so, describe treatment regimen and provide number of liters.

- 3. Dyspnea at rest?
- 4. Fatigue at rest?
- 5. Syncope from cough? Please explain cause and resolution: _____

- 6. Provide Pulse Oximetry: Room Air _____ Oxygen _____
- 7. List Pulmonary Function Test Results:

- 8. Does the pulmonary disease prevent activities of daily living? If yes, please identify.



SECTION G HEALTH CARE PROFESSIONAL Recommendations for ALL Applicants

Medical Examiner:

This report must be based on an examination conducted WITHIN THE PAST 90 DAYS or since _____.

The Secretary of the Department of Transportation is, by statute, responsible for the driver licensing decision. Your report will be advisory in determining eligibility. **The Health Care Professional's signature/license number and answers to ALL questions in Section G are required for all drivers.**

YES NO

1. In your opinion, is this person medically safe to operate a motor vehicle (car/motorcycle)?
(checking "NO" will result in automatic cancellation of driver license)
2. In your opinion, is this person medically safe to operate a commercial motor vehicle?
3. In your opinion, is this person medically safe to operate a bus and/or school bus?
4. If YES to Question #1 above, do you recommend a complete re-examination of this patient's driving ability: knowledge of rules of the road, signs and skills test, or just skills test?
5. If applicable, I reviewed the attached Driver Condition or Behavior Report.
6. Recommended Restrictions:
 Continuous Oxygen Use Required
 Daylight Driving Only
 Drive only _____ miles from home
 No Freeway or Interstate Hwy
 Roads Posted _____ mph (choose from 25-55)
 Other: _____

7. Do you recommend any additional medical evaluation?

I certify that I have examined this patient. My specialty is: _____

Print Name of Reporting Health Care Professional	Check One: MD DO	PA-C	Patient Examination Date
		APNP	
X (Signature of Reporting Health Care Professional)			Professional License Number
			(Area Code) Office Telephone Number

Pursuant to Chapter 448.01, Wis. Statutes and Trans Ch. 112.02, Wis. Admin. Code, this form must be signed by an MD, DO, PA-C or APNP.