The Registrar of Motor Vehicles requires certain applicants for a driver’s licence, or licence holders, to provide evidence of their fitness to drive. Please:

- Review section 2: Patient Questionnaire with the person;
- Refer to the National Transport Commission’s “Assessing Fitness to Drive 2012” guidelines - commercial standards for heavy vehicle licence. The guidelines are available from Austroads at www.austroads.com.au/images/stories/AFTD_reduced_for_web.pdf (your assessment must be undertaken in accordance with the guidelines);
- Complete all of sections 3, 4 and 5;
- Provide comment in the notes section on page 3 on how well controlled your patient’s condition(s) are and compliance with any medication taking.

**SELF ASSESSMENT FOR C (CAR) CLASS LICENCE HOLDERS**

You are receiving this form because you are required to complete a self assessment of your fitness to drive.

The self assessment is a requirement for all car class drivers from the age of 75 who do not have a pre-existing medical condition that is already being regularly assessed by a doctor.

While the self assessment is a compulsory requirement to retain your driver’s licence, it should be viewed as a prompt for you to regularly consider and assess your physical and mental ability to safely drive a motor vehicle to ensure you are not placing yourself or other road users at risk.

You may not need to take this form to your doctor. The answers you provide during the self assessment will determine if a visit to the doctor is required.

If you identify a medical condition that could affect your ability to drive safely, or you are unsure if a medical condition may affect your ability to drive safely, please visit your doctor and ask them to complete the Medical and Eyesight Examination (PARTS B, C and D) prior to returning the form.

You are required to either:

- Complete the self assessment process online if you have a mySA GOV account (To establish a mySA GOV account go to www.sa.gov.au/mysagov)
- OR
- Answer ALL questions in PART A: SELF ASSESSMENT (overleaf);
- Sign and date the declaration; and
- Return the completed form to GPO Box 1533, Adelaide 5001 or any Service SA Customer Service Centre.

Failure to complete and return your self assessment by the due date could lead to the suspension of your driver’s licence and penalties may apply for providing false or misleading information.
PART A: SELF ASSESSMENT (to be completed by you)

Please answer by ticking either YES, NO or UNSURE to the following questions.

IMPORTANT: If taking medication for a condition please answer YES to that condition.

<table>
<thead>
<tr>
<th>Questions</th>
<th>YES</th>
<th>NO</th>
<th>UNSURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Have you had a blackout in the last 12 months?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Have you had a heart attack, other heart problem or stroke?</td>
<td></td>
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<td></td>
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<tr>
<td>(e.g. heart failure, bypass grafting, angina, atrial fibrillation, stroke, etc)</td>
<td></td>
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<tr>
<td>3. Do you have high blood pressure that is uncontrolled and above 200 / 110?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>4. Do you have diabetes that requires medication?</td>
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<td></td>
<td></td>
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<tr>
<td>5. Do you have severe arthritis or other condition which limits movement?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>(e.g. amputation)</td>
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<tr>
<td>6. Do you have a neurological condition?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>(e.g. dementia, epilepsy, multiple sclerosis, Parkinson’s disease, etc)</td>
<td></td>
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<tr>
<td>7. Do you have a mental health or nervous condition?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>(e.g. chronic depression, anxiety, schizophrenia, etc)</td>
<td></td>
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<tr>
<td>8. Do you have a chronic sleep disorder?</td>
<td></td>
<td></td>
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<tr>
<td>(e.g. sleep apnoea, narcolepsy)</td>
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<td></td>
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<tr>
<td>9. Do you have an alcohol or drug disorder?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>(e.g. drug dependence or heavy alcohol use)</td>
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<tr>
<td>*10. Do you have an eye or vision disorder?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>(e.g. cataracts, glaucoma, one-eye vision, etc)</td>
<td></td>
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</tr>
</tbody>
</table>

If you have answered YES or UNSURE to any of the above questions you MUST take this form to a medical practitioner and have them complete the rest of the form: PARTS B to D.

*If you have answered YES or UNSURE to question 10 only, you must take this form to a Medical Practitioner, Optometrist or Ophthalmologist and have them complete PART C.

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
<th>UNSURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. Are you required to wear glasses or contact lenses while driving?</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

If you answer NO to question 11 and your driver’s licence is endorsed with a ‘S’ (corrective lenses) condition and you want the ‘S’ condition removed — you must take this form to a Medical Practitioner, Optometrist or Ophthalmologist and have them complete PART C.

DECLARATION

I declare that to the best of my knowledge the information contained in PART A of this form is true and correct.

Further, if required to have parts of this form completed by a medical practitioner, I consent to my medical practitioner releasing to the Registrar of Motor Vehicles any medical information relating to my ability to drive safely.

Print Name:_________________________________________ Driver’s Licence Number: _______________________

Signature:_________________________________________ Date: _____ / _____ / _____

Penalties apply for providing false or misleading information.

Medical information you or your doctor provide is assessed, in accordance with section 80 of the Motor Vehicles Act 1959, using the National Transport Commission Fitness to Drive Guidelines.
**PART B: MEDICAL EXAMINATION**

Only complete if person has answered YES or UNSURE to one or more questions 1 - 9 in PART A: Self Assessment.

1. **BLACKOUT**
   - Has your patient experienced a blackout? [ ] No [ ] Yes
   - If Yes, please complete the following.
   - Date of most recent episode: _____ / _____ / _____

2. **CARDIOVASCULAR DISEASE**
   - Does the patient have, or has had a cardiovascular condition? [ ] No [ ] Yes
   - If Yes, Please tick the relevant condition(s):
     - [ ] Acute Myocardial Infarction
     - [ ] Angina (If Unstable)
     - [ ] Cardiac Aneurysm
     - [ ] Cardiac Arrest
     - [ ] Cardiac Pacemaker
     - [ ] Congenital Heart Disease
     - [ ] Dilated Cardiomyopathy
     - [ ] Other Cardiovascular: ____________________________

3. **HYPERTENSION**
   - Does the patient have blood pressure consistently greater than 200 systolic or greater than 110 diastolic (treated or untreated)? [ ] No [ ] Yes

**Blood Pressure Readings**
- Systolic: ____________
- Diastolic: ____________

4. **DIABETES**
   - Does the patient have diabetes controlled by medication? [ ] No [ ] Yes
   - [ ] Yes, please complete the following.
   - Diabetes controlled by [ ] Insulin [ ] Tablet
   - Is the patient compliant with medication? [ ] No [ ] Yes
   - Does the patient experience early warning symptoms of hypoglycaemia? [ ] No [ ] Yes
   - Date of last episode: _____ / _____ / _____
   - Any end organ effects? (please specify): ____________________________

5. **MUSCULOSKELETAL CONDITION**
   - Does the patient have a musculoskeletal condition? [ ] No [ ] Yes
   - If Yes, Please tick the relevant condition(s):
     - [ ] Severe Arthritis
     - [ ] Limb
     - [ ] Other Musculoskeletal Conditions: ____________________________
     - Is the condition likely to affect driving? [ ] No [ ] Yes

6. **NEUROLOGICAL / NEUROMUSCULAR CONDITIONS**
   - Does the patient have a neurological / neuromuscular condition? [ ] No [ ] Yes
   - If Yes, Please tick the relevant condition(s):
     - [ ] Brain Aneurysm
     - [ ] Muscular Dystrophy
     - [ ] Cerebral Palsy
     - [ ] Parkinson's Disease
     - [ ] Dementia
     - [ ] Seizures*
     - [ ] Epilepsy*
     - [ ] Space-occupying Lesion (incl. brain tumour)
     - [ ] Head Injury
     - [ ] Stroke**
     - [ ] Multiple Sclerosis
     - [ ] Subarachnoid Haemorrhage*
     - [ ] Other: ____________________________
   - *Date of last episode: _____ / _____ / _____
   - **Has the patient had a stroke in the last 12 months? [ ] No [ ] Yes
   - If Yes, please provide date: _____ / _____ / _____

7. **PSYCHIATRIC CONDITION**
   - Does the patient have a severe mental health/nervous condition? [ ] No [ ] Yes
   - If Yes, Please tick the relevant condition(s):
     - [ ] Anxiety
     - [ ] Post Traumatic Stress Disorder (PTSD)
     - [ ] Bipolar Affective Disorder
     - [ ] Schizophrenia
     - [ ] Chronic Depression
     - [ ] Tourette's Syndrome
     - [ ] Personality Disorder
     - [ ] Other: ____________________________
   - Does the patient require medication? [ ] No [ ] Yes
   - If Yes - is the patient compliant with medication? [ ] No [ ] Yes

8. **SLEEP DISORDER**
   - Does the patient have a sleep disorder? [ ] No [ ] Yes
   - If Yes, please complete the following.
   - [ ] Established Sleep Apnoea Syndrome
   - [ ] Narcolepsy
   - [ ] Other: ____________________________

9. **SUBSTANCE MISUSE**
   - Does the patient currently misuse/abuse alcohol or drugs? [ ] No [ ] Yes
   - If Yes, please complete the following.
   - Does the patient abuse alcohol? [ ] No [ ] Yes
   - Does the patient use illicit drugs? [ ] No [ ] Yes
   - Does the patient misuse prescription drugs? [ ] No [ ] Yes
   - Any end organ effects? (please specify): ____________________________

10. **ADDITIONAL NOTES:**
    - (Must be completed in all cases)

**PART C: EYESIGHT CERTIFICATE** (Must be completed in all cases)

If the patient has answered YES or UNSURE to question 10 only, only PART C needs to be completed, otherwise PARTS B, C and D must be completed.

10. Does your patient have one or more of the following vision or eye disorders? Please tick:
    - [ ] Diplopia
    - [ ] Retinitis Pigmentosa
    - [ ] Monocular Vision
    - [ ] Visual Field Defect

    **Note:** If any of the above is ticked, the eyesight certificate must be completed by an Optometrist or Ophthalmologist.

    Does your patient have one or more of the following vision or eye disorders? Please tick:
    - [ ] Cataracts
    - [ ] Macular Degeneration
    - [ ] Glaucoma
    - [ ] Poor Night Vision
    - [ ] Other condition which may impair their ability to drive (please specify)

**SECTION 3: EXAMINATION REPORT**

- Medical Practitioner / Optometrist / Ophthalmologist’s Name: ____________________________
- Date: ____________
- Medical Practitioner’s signature: ____________________________
- Contact Number: ____________________________
- Provider Number: ____________________________

**SECTION 4: EYESIGHT CERTIFICATE**

- Medical Practitioner’s name: ____________________________
- Date: ____________
- Medical Practitioner’s signature: ____________________________
- Contact Number: ____________________________
- Provider Number: ____________________________

- Are glasses or contact lenses required for driving? [ ] No [ ] Yes
- Should a condition be placed on the licence? [ ] No [ ] Yes
  - (e.g. daylight hours only)

**Note:** If the patient's visual acuity with corrective lenses in the better eye or with both eyes together is worse than 6/12, this section must be completed by an Optometrist or Ophthalmologist. (Refer to Vision and Eye disorders in “Assessing Fitness to Drive” publication.)

- Are glasses or contact lenses required for driving? [ ] No [ ] Yes

**Visual acuity**
- Uncorrected: 6/____ 6/____ 6/____
- Corrected (glasses/contacts): 6/____ 6/____ 6/____

**Note:** If the patient's visual acuity with corrective lenses in the better eye or with both eyes together is worse than 6/12, this section must be completed by an Optometrist or Ophthalmologist. (Refer to Vision and Eye disorders in “Assessing Fitness to Drive” publication.)

If the condition is recorded in the Assessing Fitness to Drive publication:
- Medical Practitioner’s signature: ____________________________
- Contact Number: ____________________________
- Provider Number: ____________________________

If you are not completing PART B of this form please provide your details:
- Signature: ____________________________
- Medical Practitioner / Optometrist / Ophthalmologist's Name: ____________________________
- Date: ____________
- Provider Number: ____________________________
- Contact Number: ____________________________

Please provide a comment to each YES answer on the page overleaf under ADDITIONAL NOTES.
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SELF ASSESSMENT FOR C (CAR) CLASS LICENCE HOLDERS

MR1562 CSC 07/19

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If you require assistance please call 13 10 84 or contact a Service SA Customer Service Centre.

Section 148 of the Motor Vehicles Act 1959 requires you to inform the Registrar of Motor Vehicles if you have reasonable cause to believe that the patient is suffering from a physical or mental illness, disability or deficiency that is likely to endanger the public if the patient drives a motor vehicle.

If you consider it prudent, you may recommend that the patient undertakes a practical driving assessment. If you consider that the patient may be unfit to drive, please return this completed certificate to Locked Bag 700, Adelaide SA 5001. Information may be faxed to 8402 1977.

It is recommended that you keep a copy of this form for your own records.

On ______ / _____ / ______ I examined __________________________ (patient’s name)
(date of examination)

The patient has been treated at this clinic for ______ years ______ months.

In my opinion the person who is the subject of this report:

Meets the relevant medical standard? □ No □ Yes
If No, please provide details below:

Requires a practical driving test? □ No □ Yes
If Yes, please provide details below

Should be issued a licence subject to conditions? □ No □ Yes
If Yes, please provide details below

I certify that I personally examined the above named patient in accordance with the Assessing Fitness to Drive guidelines.

___________________________             _______________________
Medical Practitioner’s name               Date

___________________________             _______________________
Medical Practitioner’s signature         Provider Number        Telephone Number

Practice Address                         Facsimile Number

ADDITIONAL NOTES: Please provide comment to each YES answer in the medical/eyesight examination, including reference to the specific condition (e.g. 4. Diabetes).

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________