

SELF ASSESSMENT

FOR C (CAR) CLASS LICENCE HOLDERS



Government
of South Australia
Department for Infrastructure
and Transport

MR1562 CSC 12/24

Name: _____

Driver's Licence No: _____

Address: _____

Due Date: _____

Daytime phone no: _____

Email address (if available): _____

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.

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

YOU ARE REQUIRED TO EITHER:

- Complete the self assessment process online if you have a mySAGOV account
(To establish a mySAGOV 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.

When complete -
OFFICIAL: Sensitive//Medical in confidence

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.

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

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.

11. Are you required to wear glasses or contact lenses while driving?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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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.

IMPORTANT

You only need to see a medical practitioner if you have answered YES or UNSURE to questions in PART A

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 CONDITION

Does the patient have a cardiovascular condition or has the patient undergone a cardiovascular procedure? No Yes

If Yes, please complete the following.

Please tick the relevant condition(s):

- Acute Myocardial Infarction (AMI) Coronary Artery Bypass Grafting (CABG)
 Angina (If Unstable) Dilated Cardiomyopathy
 Atrial Fibrillation (AF) Heart Failure
 Cardiac Aneurysm Heart Transplant
 Cardiac Arrest Hypertrophic Cardiomyopathy
 Cardiac Pacemaker Implantable Cardioverter Defibrillator
 Congenital Heart Disorder Percutaneous Coronary Intervention (PCI or Angioplasty)
 other (please specify): _____

3. HYPERTENSION

Does your 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 your patient have diabetes controlled by medication? No Yes

If Yes, please complete the following.

Diabetes controlled by Insulin Tablet

Date of last severe hypoglycaemic episode if applicable: ____/____/____

5. MUSCULOSKELETAL CONDITION

Does your patient have a musculoskeletal condition? No Yes

If Yes, please complete the following.

Please tick the relevant condition(s):

- Severe Arthritis Limb
 Other Musculoskeletal Conditions (specify condition) _____

6. NEUROLOGICAL / NEUROMUSCULAR CONDITIONS

Does your patient have a neurological / neuromuscular condition? No Yes

If Yes, please complete the following.

Please tick the relevant condition(s):

- Brain Aneurysm Parkinson's Disease
 Cerebral Palsy Seizures - Date of last episode: ____/____/____
 Dementia Space-occupying Lesion (brain tumour) ____/____/____
 Epilepsy - Date of last episode: ____/____/____ Stroke - Date of last episode: ____/____/____
 Head Injury Subarachnoid Haemorrhage
 Multiple Sclerosis - Date of last episode: ____/____/____
 Muscular Dystrophy other (please specify): _____

7. PSYCHIATRIC CONDITION

Does your patient have a severe mental health/nervous condition? No Yes

If Yes, please complete the following.

Please tick the relevant condition(s):

- Bipolar Affective Disorder Post Traumatic Stress Disorder (PTSD)
 Chronic Anxiety Schizophrenia
 Chronic Depression Personality Disorder
 Other: _____

Does your patient require medication? No Yes

If Yes - is your patient compliant with medication? No Yes

8. SLEEP DISORDER

Does your patient have a sleep disorder? No Yes

If Yes, please complete the following.

- Established Sleep Apnoea Syndrome
 Narcolepsy Other: _____

9. SUBSTANCE MISUSE

Does your patient currently misuse alcohol or drugs? No Yes

If Yes, please complete the following.

- Alcohol
 Illicit Drugs
 Prescription drugs

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
 Other condition which may impair their ability to drive (please specify) _____

Visual acuity	Right	Left	Together
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.)

Does your patient meet the eyesight standards in the Assessing Fitness to Drive guidelines? No Yes

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)

If Yes is ticked, please provide details below:

If you are not completing PART B of this form please provide your details:

_____/_____/_____
Medical Practitioner Optometrist/
Ophthalmologist's Name Date

Signature Contact Number

Please provide comment to each YES answer on the page overleaf under ADDITIONAL NOTES.

PART D: MEDICAL PRACTITIONER'S DECLARATION

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 your patient may be unfit to drive, please immediately return the completed certificate to Locked Bag 700, GPO ADELAIDE SA 5001, or email dit.licenceservices@sa.gov.au

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

On ____ / ____ / ____ I examined _____ / ____ / ____
(Date of Examination) (Patient's name) (Date of Birth)

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

Requires a practical driving test by a Department for Infrastructure and Transport Examiner No Yes

Do you recommend conditions be placed on the licence? No Yes

Please provide further details on any of the above questions below:

Further comments on medical condition(s) affecting safe driving are attached.

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

Medical Practitioner's signature Date ____ / ____ / ____

Medical Practitioner's name

Medical Practitioner's practice address

Telephone Number Facsimile Number E-mail Address

Please complete if a specialist has assessed any of the patient's conditions in addition to the treating medical practitioner (Not required if a separate report has been provided or a specialist has completed the declaration above).

Specialist name: _____

Type of specialist: _____

Conditions assessed: _____

Specialist's signature: _____ Date: ____ / ____ / ____

If more than one specialist has undertaken an assessment, please provide your details in the section above or attach a report if applicable.