SELF ASSESSMENT

FOR C (CAR) CLASS LICENCE HOLDERS

Government of South Australia
Department for Infrastructure and Transport

MR1562 CSC 01/24

Name: _____

Address: _____

_____

_____

Daytime phone no: _____

Email address (if available): _____

_____

Driver's Licence No:

Due Date:

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?	☐	☐	☐
2. Have you had a heart attack, other heart problem or stroke? *(e.g. heart failure, bypass grafting, angina, atrial fibrillation, stroke, etc)*	☐	☐	☐
3. Do you have high blood pressure that is uncontrolled and above 200 / 110?	☐	☐	☐
4. Do you have diabetes that requires medication?	☐	☐	☐
5. Do you have severe arthritis or other condition which limits movement? *(e.g. amputation)*	☐	☐	☐
6. Do you have a neurological condition? *(e.g. dementia, epilepsy, multiple sclerosis, Parkinson's disease, etc)*	☐	☐	☐
7. Do you have a mental health or nervous condition? *(e.g. chronic depression, anxiety, schizophrenia, etc)*	☐	☐	☐
8. Do you have a chronic sleep disorder? *(e.g. sleep apnoea, narcolepsy)*	☐	☐	☐
9. Do you have an alcohol or drug disorder? *(e.g. drug dependence or heavy alcohol use)*	☐	☐	☐
*10. Do you have an eye or vision disorder? *(e.g. cataracts, glaucoma, one-eye vision, etc)*	☐	☐	☐

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?	☐	☐	☐

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)
- ☐ Angina (If Unstable)
- ☐ Atrial Fibrillation (AF)
- ☐ Cardiac Aneurysm
- ☐ Cardiac Arrest
- ☐ Cardiac Pacemaker
- ☐ Congenital Heart Disorder
- ☐ Coronary Artery Bypass Grafting (CABG)
- ☐ Dilated Cardiomyopathy
- ☐ Heart Failure
- ☐ Heart Transplant
- ☐ Hypertrophic Cardiomyopathy
- ☐ Implantable Cardioverter Defibrillator
- ☐ 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
- ☐ Cerebral Palsy
- ☐ Dementia
- ☐ Epilepsy - Date of last episode: _____ /_____ /_____
- ☐ Head Injury
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Parkinson's Disease
- ☐ Seizures - Date of last episode: _____ /_____ /_____
- ☐ Space-occupying Lesion (brain tumour)
- ☐ Stroke - Date of last episode: _____ /_____ /_____
- ☐ Subarachnoid Haemorrhage - Date of last episode: _____ /_____ /_____
- ☐ 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
- ☐ Chronic Anxiety
- ☐ Chronic Depression
- ☐ Other: _____
- ☐ Post Traumatic Stress Disorder (PTSD)
- ☐ Schizophrenia
- ☐ Personality Disorder

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
- ☐ Monocular Vision
- ☐ Retinitis Pigmentosa
- ☐ 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
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ 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 **GPO BOX 1533, Adelaide SA 5001, or email dit.medicalpdamatters@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.