CERTIFICATE OF FITNESS - HEAVY VEHICLE DRIVERS/ COMMERCIAL VEHICLE DRIVERS

Government of South Australia
Department of Planning, Transport and Infrastructure

MR713 02/17

Driver's Licence No:/
Driver Accreditation No:

Class of Licence:

Class of Accreditation:

Due Date:

SECTION 1: YOUR DETAILS (to be completed in BLOCK letters prior to seeing your doctor)

APPLICANT'S DECLARATION

Surname_____

Given names_____

Home address_____

Suburb/Town_____ Postcode_____ Phone (B/Hr)_____

Postal address if different from above_____

Email address (if available) _____

I declare that to the best of my knowledge the information regarding my medical background is true and correct and that I have made the examining medical practitioner aware of any medical condition that I have and drugs or medication that I use.
I consent to my medical practitioner and/or treating specialist releasing to the Department of Planning, Transport and Infrastructure any medical information relating to my ability to drive safely.

Signature_____

A person must not, in providing information, make a statement that is false or misleading. Penalties apply.

IMPORTANT NOTES FOR THE MEDICAL PRACTITIONER

The Registrar of Motor Vehicles requires certain applicants for a driver's licence, or licence holders, to provide evidence of their fitness to drive. Additionally, an applicant for driver accreditation under the *Passenger Transport Act 1994* is required to satisfy the Department of Planning, Transport and Infrastructure that they do not suffer any physical or mental incapacity that would impair their ability to work effectively as the driver of a public passenger vehicle and handle passengers. Please:

- Review section 2: Patient Questionnaire with the person;
- Refer to the National Transport Commission's "Assessing Fitness to Drive 2016" guidelines - commercial standards for heavy vehicle licence. The guidelines are available from Austroads at www.austroads.com.au
  (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.

WHAT TO DO WITH THE COMPLETED MEDICAL ASSESSMENT

Return to GPO Box 1533, Adelaide 5001 or any Service SA Customer Service Centre.
Enquiries: 13 10 84

SECTION 2: PATIENT QUESTIONNAIRE (to be completed by patient prior to medical examination)

Please answer the questions by ticking the correct box. If you are not sure, leave the question blank and ask your medical practitioner what it means. They will ask you additional questions during the examination.

	YES	NO
1. Are you currently being treated by a medical practitioner for any illness or injury?	☐	☐
2. Have you consulted any other medical practitioner within the last 12 months?	☐	☐
3. Are you receiving any medical treatment or taking any medication (Either prescribed or otherwise)?	☐	☐

If Yes to question 1 or 2 please provide details, including the name of medical practitioner or treating specialist

4. Have you ever had, or been told by a medical practitioner that you had, any of the following:		
4.1 High blood pressure	☐	☐
4.2 A blood pressure reading of 170/100 or higher (treated or untreated)	☐	☐
4.3 Heart disease	☐	☐
4.4 Chest pain, Angina	☐	☐
4.5 Any conditions requiring heart surgery	☐	☐
4.6 Palpitations/Irregular heartbeat	☐	☐
4.7 Abnormal shortness of breath	☐	☐
4.8 Head injury, Spinal injury	☐	☐
4.9 Seizures, Fits, Convulsions, Epilepsy	☐	☐
4.10 Blackouts, Fainting	☐	☐
4.11 Stroke	☐	☐
4.12 Neurological disorder	☐	☐
4.13 Psychiatric illness, nervous disorder	☐	☐
4.14 Dizziness, vertigo, problems with balance	☐	☐
4.15 Any vision or eye issues or defects	☐	☐
4.16 Diabetes	☐	☐
4.17 Neck, back or limb disorders	☐	☐
4.18 Hearing loss or deafness or use a hearing aid	☐	☐
4.19 Have you had any other serious injury, illness, operation or been in hospital for any reason in the last 5 years?	☐	☐
5. Have you ever had, or been told by a medical practitioner that you had a sleep disorder, sleep apnoea or narcolepsy?	☐	☐

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?
This refers to your usual way of life in recent times. Even if you haven't done some of these things recently, try to work out how they would have affected you.

0 = would never doze off
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

It is important that you put a number (0 to 3) in each of the 8 boxes.

Situation:	Chance of dozing (0-3)
• Sitting and reading	
• Watching TV	
• Sitting, inactive in a public place (e.g. a theatre or meeting)	
• As a passenger in a car for an hour without a break	
• Lying down to rest in the afternoon when circumstances permit	
• Sitting and talking to someone	
• Sitting quietly after a lunch without alcohol	
• In a car, while stopped for a few minutes in the traffic	

6. Do you consume alcohol?
No ☐ **Yes** ☐

7. Have you used illicit drugs in the last 5 years?
No ☐ **Yes** ☐ *If Yes please provide details in Question 8*

8. Do you use any drugs or medications not prescribed for you by a medical practitioner?
No ☐ **Yes** ☐ *If Yes please provide details:*

9. Have you been the driver of a vehicle involved in a crash in the last 5 years?
No ☐ **Yes** ☐ *If Yes please provide details:*

10. Nature of Driving Task

10.1 Are you currently driving heavy/commercial vehicles?
No ☐ **Yes** ☐

10.2 Do you drive locally or interstate? Please provide details (with approximate distances).

10.3 Approximately how many hours per day do you drive heavy vehicles?

10.4 Do you drive public passenger vehicles eg bus, taxi, or hire car?
No ☐ **Yes** ☐

10.5 Do you drive a vehicle carrying bulk dangerous goods?
No ☐ **Yes** ☐

SECTION 3: EXAMINATION REPORT

1. BLACKOUT

Has the 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 Disorder
- ☐ Dilated Cardiomyopathy
- ☐ Coronary Artery Bypass Grafting (CABG)
- ☐ Heart Failure
- ☐ Heart Transplant
- ☐ Hypertrophic Cardiomyopathy
- ☐ Implantable Cardioverter Defibrillator (ICD)
- ☐ Percutaneous Coronary Intervention (Angioplasty)
- ☐ Other Cardiovascular: _____

(N.B if patient has an ICD implanted they may not be eligible to hold a commercial class of licence, please refer to national guidelines.)

3. HYPERTENSION

Does the patient have blood pressure consistently greater than 170 systolic or greater than 100 diastolic (treated or untreated)? ☐ No ☐ **Yes**

Blood Pressure Readings

Systolic: _____ **Diastolic:** _____

4. DIABETES

Does the patient have diabetes controlled by medication? ☐ No ☐ **Yes**

If Yes, please complete the following.

Diabetes controlled by ☐ Insulin ☐ Other: _____

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. HEARING LOSS

Does the patient have severe hearing loss? ☐ No ☐ **Yes**

If Yes, referral is required to an appropriate ENT specialist or audiologist.

6. MUSCULOSKELETAL DISORDER

Does the patient have a musculoskeletal disorder? ☐ No ☐ **Yes**

***If Yes*, please tick the relevant condition(s):**

- ☐ Arthritis
- ☐ Limb
- ☐ Other Musculoskeletal Disorders _____

Is the condition likely to affect driving? ☐ No ☐ **Yes**

7. NEUROLOGICAL / NEUROMUSCULAR CONDITIONS

Does the patient have a neurological / neuromuscular condition? ☐ No ☐ **Yes**

***If Yes*, please tick the relevant condition(s):**

- ☐ Brain Aneurysm
- ☐ Cerebral Palsy
- ☐ Dementia
- ☐ Epilepsy*
- ☐ Head Injury
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Parkinson's Disease
- ☐ Seizure*
- ☐ Space-occupying Lesion (incl. brain tumour)
- ☐ Stroke**
- ☐ 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: _____ /_____ /_____

8. PSYCHIATRIC DISORDER

Does the patient have a severe mental health/nervous disorder? ☐ No ☐ **Yes**

***If Yes*, please tick the relevant condition(s):**

- ☐ Anxiety Disorder
- ☐ Bipolar Affective Disorder
- ☐ Chronic Depression
- ☐ Personality Disorder
- ☐ Post Traumatic Stress Disorder (PTSD)
- ☐ Schizophrenia
- ☐ Tourette's Syndrome
- ☐ Other: _____

Does the patient require medication? ☐ No ☐ **Yes**

If Yes - is the patient compliant with medication? ☐ No ☐ **Yes**

9. SLEEP DISORDER

Does the patient have a sleep disorder? ☐ No ☐ **Yes**

If Yes, please complete the following.

Established Sleep Apnoea Syndrome ☐ No ☐ **Yes**

Narcolepsy ☐ No ☐ **Yes**

Other: _____ ☐ No ☐ **Yes**

(Referral is required to an appropriate specialist for all commercial drivers with diagnosed Sleep Disorder.)

10. 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): _____

SECTION 4: EYESIGHT CERTIFICATE

(Must be completed in all cases)

11. If the patient has one or more of the following eye or vision condition, please tick.

- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Retinitis Pigmentosa
- ☐ Diplopia
- ☐ Visual Field Defect
- ☐ Glaucoma
- ☐ Poor Night Vision
- ☐ Other conditions which may impair their ability to drive (please specify):

_____

Note: If the patient has one or more of the above conditions and the eyesight standards are not met (aided) an Optometrist or Ophthalmologist must complete the Eyesight Certificate.

Additionally, if your patient's visual acuity with corrective lenses in the better eye or with both eyes together is worse than 6/9, or their visual field is worse than the criteria contained in the Assessing Fitness to Drive guidelines, an Optometrist or Ophthalmologist must complete the Eyesight Certificate.

Does the patient have Monocular Vision? ☐ No ☐ **Yes**

If 'Yes' then Eyesight Certificate must be completed by an Optometrist or Ophthalmologist.

Visual acuity	Right	Left	Together
Uncorrected	6/_____	6/_____	6/_____
Corrected (glasses/contacts)	6/_____	6/_____	6/_____

Does your patient meet the eyesight standards in the Assessing Fitness to Drive 2016 guidelines? ☐ No ☐ **Yes**
(refer to vision and eye disorders in "Assessing Fitness to Drive" publication)

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, please provide details below.

If you are not completing the other sections of this form please complete the following.

_____ _____ /_____ /_____

Medical Practitioner / Optometrist's Name *Date*

_____ _____ _____

Medical Practitioner / Optometrist's Signature *Provider Number* *Contact Number*

ADDITIONAL NOTES: Provide comment to each ☑ **Yes** condition(s) below including reference to the specific condition (e.g. 4. Diabetes).

SECTION 5: MEDICAL PRACTITIONER'S DECLARATION

Under section 148 of the Motor Vehicles Act 1959 you have a legal obligation 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 or necessary you may recommend that the patient undertakes a practical driving assessment. This is irrespective of the patient's age or driver's licence class. Patients who hold a licence other than a "car" licence are required to undergo a practical driving assessment at age 85 and every year thereafter.

If you consider that the patient may be unfit to drive, you are requested to immediately return the completed certificate to Licence Regulation; **Locked Bag 700, Adelaide SA 5001** or fax information to 8402 1977.

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

MEDICAL PRACTITIONER'S DECLARATION (to be completed by Medical Practitioner)

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 Yes ☐ No ☐
If no, please provide details below:

If no, does the person meet the standards for a light vehicle licence? Yes ☐ No ☐

Requires a practical driving test Yes ☐ No ☐

Do you recommend conditions be placed on the licence? Yes ☐ No ☐
If yes, please provide details 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 2016 guidelines.

If the applicant holds driver accreditation, I have considered that they are medically and psychologically fit to drive a public passenger vehicle and handle passengers.

_____ ____ /____ /____
Medical Practitioner's signature Date

_____ _____
Medical Practitioner's name Provider Number

_____
Practice Address

_____ _____ _____
Telephone Number Facsimile Number E-mail Address