COMMERCIAL VEHICLE DRIVER MEDICAL ASSESSMENT

This Medical Assessment meets the requirements of the following Western Australian Government Authorities;

Department of Consumer and Employment Protection, WorkSafe - Occupational Safety and Health Regulations (1996)

Main Roads Western Australia - Heavy Vehicle Accreditation 2003

Department of Consumer and Employment Protection, Resources Safety Division - Dangerous Goods (Transport) (Road and Rail) Regulations 1999

Important Information:

1. PLEASE READ THE INSTRUCTIONS ACCOMPANYING THIS FORM.
2. COPIES OF PAGES 1 AND 2 OF THIS FORM NEED TO BE PROVIDED TO YOUR EMPLOYER, AS PROOF OF FITNESS TO DRIVE A COMMERCIAL VEHICLE.
3. IF YOU ARE APPLYING FOR A DANGEROUS GOODS BULK LICENCE, ANY COPIES OF THIS FORM WHICH ARE TO BE SENT IN WITH YOUR APPLICATION (TO THE RESOURCES SAFETY DIVISION OF THE DEPARTMENT OF CONSUMER AND EMPLOYMENT PROTECTION) MUST BE CLEARLY CERTIFIED AS COPIES BY YOUR MEDICAL PRACTITIONER.
4. THE ORIGINAL OF THIS FORM - SHOULD BE KEPT BY YOU (THE APPLICANT), SO THAT ANY FUTURE EMPLOYER CAN GET A COPY FROM YOU FOR THEIR RECORDS.
5. EXCEPT FOR DANGEROUS GOODS BULK LICENCE APPLICATIONS, THIS FORM DOES NOT NEED TO BE SENT TO ANY WA GOVERNMENT AUTHORITY.

Applicant details – to be completed by the applicant

Family Name:		*I consent to the relevant Departments mentioned above contacting my Medical Practitioner for any further information relevant to their assessment of my fitness*	
Given Names:			
Date of Birth		**Applicant's signature** **Date**	
Driver Licence Number		Licence class:	Expiry date:
☐ Licence application		☐ Renewal of current licence	

Assessment of Fitness to Drive – to be completed by medical practitioner

Were you familiar with the patient's medical history prior to this examination? ☐ YES ☐ NO

If you answered no, to the above how long have you been treating this person________________

Patient examined according to

☐ Commercial vehicle standards ☐ Private vehicle standards

I certify that I have examined the above mentioned patient in accordance with the relevant National Medical Standards (private or commercial) as set out in Assessing Fitness to Drive, 2003. In my opinion the person subject of this report:

☐ ***Meets*** the relevant medical criteria	➞	***Criteria met*** (no further information required)
☐ ***Does not meet*** the relevant medical criteria	➞	***Criteria not met – provide details*** (please detail any concerns at page 6 "relevant clinical findings")
☐ *Does not* **meet the criteria, however may be suitable to drive a commercial vehicle subject to the applicant meeting the conditions set out in the box below**	➞	***A certificate may be issued with conditions imposed*** Please detail in the box below the recommended restrictions and/or monitoring requirements for a conditional licence. For example the applicant must wear prescription lenses for driving or that there must be a periodic medical review. Note that this section is NOT for detailing any relevant medical conditions that the applicant may have. ***Note that a conditional certificate will not be issued unless adequate supporting information is provided by the examining medical practitioner to the relevant licensing authorities.***
Conditions (if any) which must be met to allow the applicant to drive commercial vehicle are as follows: *Important – see note above before completing this section*		

Medical Practitioner Details [Please Print]

Reporting Practitioners Name	
Business Address	
Telephone ( ) Fax ( )	Date of Examination
Signature	
☐ Further comments on medical condition(s) affecting the applicants driving are attached	

The Western Australian Government Authorities listed on this Assessment Form have a responsibility to ensure that all drivers covered by their particular legislation are medically fit. To meet this responsibility, legislation gives those Authorities the ability to require any licence holder or applicant to provide medical evidence of their fitness.

To the Driver/Applicant

• Make an appointment with your medical practitioner. • As the examination may take longer than a routine consultation, please advise the receptionist when making the appointment that you are attending for this purpose. • If you wear spectacles, hearing aids etc, please bring them to the examination. • Take this form to the appointment for your doctor to complete. • You must make the doctor aware of any medical conditions you may have so that your doctor can conduct an informed assessment, using this form. • If the medical report has been requested for a particular reason, you should let your practitioner know this reason.	• On completion of the examination the doctor will provide you with the form for you to either retain or if required return to the relevant Licensing Authority for a Dangerous Goods Bulk Licence

2.2 Patient Questionnaire

The self-administered questionnaire has been designed as a screening tool to help identify conditions that might affect driving ability. Completion of the questionnaire is a formal requirement of the examination (e.g. for commercial vehicle drivers or dangerous goods licenses).

The completed questionnaire should be retained by the patient for reasons of privacy (refer Assessing Fitness To Drive manual, section 3.3.3, page 18) except if a certified copy is required by the relevant Authority in the case of an applicant for a Dangerous Goods Bulk licence.

Note: The health professional may need to guide or assist with completion of the questionnaire if literacy or cultural background presents a barrier to self-administration by the patient.

ASSESSING FITNESS TO DRIVE – PATIENT QUESTIONNAIRE

Name:_____________________________________ **Address:**_______________________________________

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

	No	Yes
1. Are you currently being treated by a doctor for any illness or injury	☐	☐
2. Are you receiving any medical treatment or taking any medication (either prescribed or otherwise) *(Please take any medications with you to show the doctor)*	☐	☐
3. Have you ever had, or been told by a doctor that you had any of following?		
3.1 High blood pressure	☐	☐
3.2 Heart disease	☐	☐
3.3 Chest pain, angina	☐	☐
3.4 Any condition requiring heart surgery	☐	☐
3.5 Palpitations/irregular heartbeat	☐	☐
3.6 Abnormal shortness of breath	☐	☐
3.7 Head injury, spinal injury	☐	☐
3.8 Seizures, fits, convulsions, epilepsy	☐	☐
3.9 Blackouts, fainting	☐	☐
3.10 Stroke	☐	☐
3.11 Dizziness, vertigo, problems with balance	☐	☐
3.12 Double vision, difficulty seeing	☐	☐
3.13 Colour blindness	☐	☐
3.14 Kidney disease	☐	☐
3.15 Diabetes	☐	☐
3.16 Neck, back or limb disorders	☐	☐
3.17 Hearing loss or deafness or had an ear operation or use a hearing aid	☐	☐
3.18 Do you have difficulty hearing people on the telephone (including use of hearing aid if worn)?	☐	☐
3.19 Have you ever had, or been told by a doctor that you had a psychiatric illness, or nervous disorder	☐	☐
3.20 Have you ever had any other serious injury, illness, operation, or been in hospital for any reason?	☐	☐
4.1 Have you ever had, or been told by a doctor that you had a sleep disorder, sleep apnoea, or narcolepsy?	☐	☐
4.2 Has anyone noticed that your breathing stops or is disrupted by episodes of choking during your sleep?	☐	☐

4.3 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.

Use the following scale to choose the most appropriate number for each situation: *0 = would never doze off* *2 = moderate chance of dozing*
1 = slight 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	☐

5. Please circle the answer that is correct for you:

5.1 How often do you have a drink containing alcohol?

Never | *Monthly or less* | *Two or four times a month* | *Two to three times a week* | *Four or more times a week*

5.2 How many drinks containing alcohol do you have on a typical day when you are drinking?

1 or 2 | *3 to 5* | *5 to 6* | *7 to 9* | *10 or more*

5.3 How often do you have six or more drinks on one occasion?

Never | *Less than monthly* | *Monthly* | *Weekly* | *Daily or almost daily*

5.4 How often during the last year have you found that you were not able to stop drinking once you had started?

Never | *Less than monthly* | *Monthly* | *Weekly* | *Daily or almost daily*

5.5 How often during the last year have you failed to do what was normally expected from you because of drinking?

Never | *Less than Monthly* | *Monthly* | *Weekly* | *Daily or almost daily*

5.6 How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

Never | *Less than Monthly* | *Monthly* | *Weekly* | *Daily or almost daily*

5.7 How often during the last year have you had a feeling a guilt or remorse after drinking?

Never | *Less than monthly* | *Monthly* | *Weekly* | *Daily or almost daily*

5.8 How often during the last year have you been unable to remember what happened the night before because you had been drinking?

Never | *Less than monthly* | *Monthly* | *Weekly* | *Daily or almost daily*

5.9 Have you or someone else been injured as a result of your drinking?

No | *Yes, but not in the last year* | *Yes, during the last year*

5.10 Has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?

No | *Yes, but not in the last year* | *Yes, during the last year*

(Scoring of the AUDIT questionnaire is shown in the section on Alcohol page 31).

	No	Yes
6. Do you use illicit drugs?	☐	☐
7. Do you use any drugs or medications not prescribed for you by a doctor?	☐	☐
8. Have you been in a vehicle crash since your last licence examination? If Yes, please give details:	☐	☐

____

____

Applicant's Declaration (in presence of doctor):

I, ____

certify that to the best of my knowledge the above information supplied by me is true and correct

Signature: ____

Date: _____/_____/_____

IMPORTANT
For privacy reasons, the completed Patient Questionnaire must not be returned to department. Medical information relevant to driver licensing should be included on the Medical Certificate.

To the Medical Practitioner

- The examination must be conducted in accordance with the national medical standards described ***in Assessing Fitness to Drive 2003.*** This publication is available from the Department for Planning and Infrastructure Licensing Call Centre on 131156 or on the Internet (www.austroads.com.au). It details the examination process and provides examination proforma to guide you.
- Upon completion of the examination please complete and sign the certificate overleaf.

Distribute the completed certificate as follows:

- Provide the original certificate (together with additional information relevant to the patient's fitness to drive) to the patient.
- Retain a copy for the patient's medical record, together with detailed examination notes.
- If you have doubts about your patient's suitability to drive, you may suggest a referral to a suitable specialist. Please indicate this on the form.
- *Criminal Liability & Insurance* – Health professionals may be liable under civil law in cases where a court forms the opinion that they have not taken reasonable steps to ensure that impaired drivers drive only in circumstances that do not place them and other members of the community at increased risk. Professional indemnity insurers are aware of the potential liability of health professionals and may reasonably expect health professionals to comply with the national medical standards.

Conditions and Restrictions

- If appropriate, the practitioner may recommend conditions, which may enhance driver competency or safety and allow their patient to continue to drive (e.g. corrective lenses, no night driving, additional mirrors).
- If the practitioner recommends a conditional approval, details of the recommended restrictions and reasons must be provided, otherwise a conditional approval will not be considered

Clinical Examination Proforma

The Clinical Examination Proforma is another tool designed to help guide the examination process. It provides a standard format for recording the results of the examination, which should then be filed in the patient's history. As for the Patient Questionnaire, completion of the Clinical Examination Proforma is a formal requirement of the examination (e.g. for commercial vehicle drivers and dangerous goods licences).

The completed Clinical Examination Proforma is not to be forwarded to the relevant Authority, for reasons of privacy (refer Assessing Fitness to Drive manual, section 3.3.4, page 18). Details relevant to the patient's fitness to drive should be transferred to the Assessment of Fitness to Drive Medical Certificate (see page 2).

Appendix 2.3 CLINICAL EXAMINATION PROFORMA

Name:____

Address:____

The examiner will be guided by findings in the questionnaire or a referral letter and may apply appropriate tests other than those outlined here, e.g. **Mini Mental State** or equivalent for cognitive conditions. This form is to be retained by the examining doctor and not returned to the relevant Authority. Findings relevant to the person's fitness to drive should be recorded on the Medical Certificate supplied to the patient.

1. Cardiovascular System:

1.1 Blood Pressure (repeat if necessary)

Systolic ☐ mm Hg ☐ mm Hg
Diastolic ☐ mm Hg ☐ mm Hg

1.2 Pulse Rate: ☐

Regular ☐ Irregular ☐

1.3 Heart Sounds:

Normal ☐ Abnormal ☐

1.4 Peripheral Pulses:

Normal ☐ Abnormal ☐

2. Chest/Lungs: Normal ☐ Abnormal ☐

3. Abdomen(liver):

Normal ☐ Abnormal ☐

4. Neurological/Locomotor:

4.1 Cervical spine rotation

Normal ☐ Abnormal ☐

4.2 Back movement

Normal ☐ Abnormal ☐

4.3 Upper Limbs

(a) Appearance

Normal ☐ Abnormal ☐

(b) Joint movements

Normal ☐ Abnormal ☐

4.4 Lower Limbs

(a) Appearance

Normal ☐ Abnormal ☐

(b) Joint movements

Normal ☐ Abnormal ☐

4.5 Reflexes

Normal ☐ Abnormal ☐

Romberg's sign (A pass requires the ability to maintain balance while standing with shoes off, feet together side by side, eyes closed and arms by sides, for thirty seconds):

Normal ☐ Abnormal ☐

5. Vision:

5.1 Visual Acuity

Uncorrected		Corrected	
R	L	R	L
6/	6/	6/	6/

Are contact lenses worn?

No ☐ Yes ☐

5.2 Visual Fields (Confrontation to each eye):

Normal ☐ Abnormal ☐

6. Hearing (Commercial drivers only)

Normal ☐ Abnormal ☐

7. Urinalysis

7.1 Protein:

Normal ☐ Abnormal ☐

7.2 Glucose:

Normal ☐ Abnormal ☐

8. Neuropsychological Assessment. Where clinically indicated apply the Mini Mental State Questionnaire or General Health Questionnaire or equivalent.

Score: ☐

RELEVANT CLINICAL FINDINGS

These findings should be comments on any relevant findings detected in the questionnaire or examination, making reference to the requirements of the standards outlined in the Assessing Fitness To Drive publication.
(Attach separate sheet if necessary)