(Form Revised September 2016)

THE FORM SHOULD BE COMPLETED BY THE EXAMINING HEALTH PROFESSIONAL AND PROVIDED TO THE REQUESTING ORGANISATION/DRIVER

A COPY SHOULD BE RETAINED BY THE EXAMINING HEALTH PROFESSIONAL

Assessing Fitness to Drive 2016

Health Assessment for Commercial Vehicle Driver

FITNESS TO DRIVE REPORT

(Note: this report relates to the driver's fitness for duty and is not to be used for driver licensing assessments)

Driver information:	Surname:	Given name(s):	
Address:			
Phone:	Date of birth:	Driver Licence no.	State of issue:
Employer information:	Name:		
Address:		Contact phone number:	
Nature of driving duties:			

Assessment outcome:

I was familiar with the driver's medical history before conducting this assessment ☐ Yes ☐ No

I have sighted the driver's licence ☐ Yes ☐ No

I have examined the driver in accordance with Assessing Fitness to Drive 2016 standards for commercial vehicle drivers, and in my opinion the driver (tick ONE box from 1 to 4 and indicate recommended management):

☐ **1. Unconditionally meets the medical criteria for fitness to drive**

Meets all relevant medical criteria. No restrictions or conditions. See recommended date of next review below.

☐ **2. Conditionally meets the medical criteria for fitness to drive**

Has a medical condition that may impact on fitness to drive, but it is well controlled and meets the **conditional** criteria in *Assessing Fitness to Drive 2016.* May require person to be more frequently reviewed than prescribed under normal periodic review. See recommended date of next review below.

Person is required to wear the following aids/devices:

☐ Corrective lenses ☐ Hearing aid ☐ Other aids/devices (specify):

☐ **3. Temporarily does not meet the medical criteria for fitness to drive**

Does not meet relevant medical criteria (Unconditional or Conditional) and should not undertake normal driving duties. May perform alternative tasks. May return to driving following: an improvement in condition, response to treatment or confirmed diagnosis of undifferentiated illness.

☐ **4. Permanently does not meet the medical criteria for fitness to drive**

Does not meet relevant medical criteria and cannot perform normal driving duties in the foreseeable future.

Recommended management:

☐ Local doctor referral
☐ Specialist referral
☐ Laboratory tests
☐ Drug test
☐ Practical driver test
☐ More frequent periodic review (see recommended review date below)
☐ Other, please describe (Please attached additional information to the form if required)

Recommended date of next review (from date of assessment):

☐ 1 year ☐ 2 years ☐ 3 years ☐ 4 years ☐ 5 years ☐ Other (specify)

Health professional's details

Name:	Phone:	Facsimile:
Practice address:		
Signature:	Date of assessment:	

CLINICAL ASSESSMENT RECORD

Driver information:

Surname:	Given name(s):
Address:	
Date of birth:	Phone:
Driver licence number:	State of issue:

Employer information:

Employer name:	
Address:	Phone:

Nature of driving duties:

CLINICAL ASSESSMENT:

1. Vision

1.1 Visual acuity (refer AFTD, page 124, 129)

Are glasses or contact lenses worn? ☐ Yes ☐ No

	R	L	Both
Without Correction	6 /	6 /	6 /
With Correction	6 /	6 /	6 /

Meets criteria ☐ Without correction ☐ With correction

Does not meet criteria ☐

1.2 Visual Fields ☐ Normal ☐ Abnormal (refer AFTD, page 125-26, 128)

Comments:

2. Hearing (refer AFTD, page 67-69 including flowchart)

Assess clinically in the first instance. Audiometry is only required if clinical assessment indicates possible hearing loss. *(Clinical tests used to screen for hearing impairment include testing whether a person can hear a whispered voice, a finger rub, or a watch tick at a specific distance. Perceived hearing loss can be assessed by asking a single question (for example, "Do you have difficulty with your hearing?" as per the Driver Health Questionnaire)*

Possible hearing loss? ☐ Yes ☐ No

If yes, are hearing aids worn? ☐ Yes ☐ No

Refer for audiometry if indicated:

Hearing level at frequencies (db)

	0.5kHz	1.0kHz	1.5kHz	2.0kHz	3.0kHz	4.0kHz	6.0kHz	8.0kHz	Average of 0.5,1,2,3 kHz
Right ear									
Left ear									

Meets criteria ☐ Without hearing aid ☐ With hearing aid

Does not meet criteria ☐

Comments:

3. Cardiovascular system (refer AFTD page 39-58)

Relevant findings from questionnaire:

Blood pressure	Repeated (if necessary)
Systolic	Systolic
Diastolic	Diastolic

Pulse rate beats/min ☐ Normal ☐ Abnormal

Heart sounds ☐ Normal ☐ Abnormal

Peripheral pulses ☐ Normal ☐ Abnormal

Comments (including comments regarding overall cardiac risk and risk factors e.g. obesity, smoking, exercise, stress):

4. Diabetes (Refer AFTD page 59-66)

Existing diabetes? ☐ No ☐ Yes

Comments:

5. Musculoskeletal / neurological system

(Refer AFTD page 71-75, 76-105)

Comments include relevant findings from questionnaire including existing neurological and musculoskeletal conditions:

Cervical spine rotation		☐ Normal	☐ Abnormal
Back movement		☐ Normal	☐ Abnormal
Upper limbs:	(a) Appearance	☐ Normal	☐ Abnormal
	(b) Joint movements	☐ Normal	☐ Abnormal
Lower limbs:	(a) Appearance	☐ Normal	☐ Abnormal
	(b) Joint movements	☐ Normal	☐ Abnormal
Reflexes		☐ Normal	☐ Abnormal
Romberg's sign*		☐ Normal	☐ Abnormal

(* 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)

Functional/ practical assessment required?

☐ No ☐ Yes

Comments:

6. Psychological health (Refer AFTD page 107-110)

Relevant findings from questionnaire:

Mental state examination:

Appearance	☐ Normal	☐ Abnormal
Attitude.....	☐ Normal	☐ Abnormal
Behaviour.....	☐ Normal	☐ Abnormal
Mood and affect.....	☐ Normal	☐ Abnormal
Thought form stream and content.....	☐ Normal	☐ Abnormal
Perception.....	☐ Normal	☐ Abnormal
Cognition.....	☐ Normal	☐ Abnormal
Insight.....	☐ Normal	☐ Abnormal
Judgement.....	☐ Normal	☐ Abnormal

Comments:

7. Sleep disorders (Refer AFTD page 112-115)

Existing sleep disorder? ☐ No ☐ Yes

ESS Score (Screen):
(Q 5 of Driver Health Questionnaire)

(Score > 16 is consistent with moderate to severe excessive daytime sleepiness. Do not rely solely on the ESS to rule out sleep apnoea)

Clinical signs of sleep disorder ☐ Absent ☐ Present

Comments:

8. Substance misuse (Refer AFTD page 117 -121)

Note: Drug screening not routinely required.

Existing substance use disorder? ☐ No ☐ Yes

Audit Score (Screen):
(Q6 of Driver Health Questionnaire)

(Score > 8 indicates strong likelihood of hazardous or harmful alcohol consumption)

Clinical signs of substance misuse ☐ Absent ☐ Present

Comments:

9. Medication

Specify:

SUMMARY

Summarise significant findings

Are any further investigations or referrals required? ☐ Yes (describe) No ☐

What is the recommendation for this driver in terms of fitness to drive?

☐ **Unconditionally** meets the medical criteria – meets all relevant medical criteria (no restrictions)

☐ **Conditionally** meets the medical criteria for fitness to drive – has a medical condition that may impact on fitness to drive but it is well controlled and meets the conditional criteria in *Assessing Fitness to Drive 2016*. Indicate also if:

- ☐ Driver requires aids to drive:
  - ☐ Vision aids ☐ Hearing aids ☐ Other devices or vehicle modifications (specify)
- ☐ Driver requires more frequent review than prescribed under normal periodic review:
  - Specify recommended review:

☐ **Temporarily** does not meet the medical criteria (unconditional or conditional) – pending further investigation and treatment (record details).

☐ **Permanently** does not meet the medical criteria (record details)

Contact(s) with other treating health professional(s)

Note: Contact is to be made with patient's consent as per questionnaire

Contact with requesting organisation (if relevant and clinically warranted)

☐ If the driver is classified *Temporarily or Permanently does not meet the medical criteria*, send Fitness to Drive Report immediately to requesting organisation, if relevant.

Details of contact made

Name of doctor	Signature of doctor	Date

Assessing Fitness to Drive 2016

Health Assessment for Commercial Vehicle Driver

DRIVER HEALTH QUESTIONNAIRE

(to be completed by driver)

Driver information:

Surname:	Given name(s):
Address:	
Date of birth:	Phone:
Driver licence number:	State of issue:

Employer information:

Employer name:	
Address:	Phone:

Instructions for completion:

Please answer the questions by ticking the appropriate box. If you are not sure what a question means, leave the answer blank and the health professional will help you. The health professional will ask you additional questions during the assessment. On completion of the questionnaire you will be asked to sign a declaration to confirm the accuracy of your responses.

Please bring with you to the assessment:

- A list of current prescription, non-prescription and complementary medicines
- Glasses/contact lenses and hearing aids if you use them
- Disease management plans (e.g. sleep disorder management plan, diabetes management plan)

Disclosure of health information:

Please read carefully and sign to indicate you understand how health information is reported, stored and accessed.

The details of your health assessment will remain confidential and will only be reported to the requesting organisation in terms of whether you meet the medical criteria for driving a commercial vehicle. The examining health professional retains all detailed health documentation including your questionnaire responses and the completed record of clinical findings. The examining health professional will provide you with the report form to return to the requesting organisation indicating your fitness for duty classification. Other than the above, your personal information will not be disclosed to any other person or organisation without your written permission, except when required by law.

You have the right to access your health records including those held by the examining health professional and the reports held by the requesting organisation.

Driver's declaration

I have read and understood the above statement concerning the health information provided in this document.

Signature of driver	Date

Consent to contact treating health professionals

I consent to the examining doctor contacting my treating health professionals to clarify aspects of my medical management.

Signature of driver	Date

Questions:

1.	Are you currently attending a health professional for any illness, injury or disability?	☐ No ☐ Yes
2.	Are you taking any prescription, non-prescription or complementary medicines?	☐ No ☐ Yes

If YES to Question 1 or 2 please provide brief details:

Health professional's comments:

3. Do you suffer from or have you ever suffered from any of the following:

3.1	High blood pressure	☐ No ☐ Yes	**3.11**	Stroke	☐ No ☐ Yes
3.2	Heart disease	☐ No ☐ Yes	**3.12**	Dizziness, vertigo, problems with balance	☐ No ☐ Yes
3.3	Chest pain, angina	☐ No ☐ Yes	**3.13**	Memory loss or difficulty with attention or concentration	☐ No ☐ Yes
3.4	Any condition requiring heart surgery	☐ No ☐ Yes	**3.14**	Other neurological disorder	☐ No ☐ Yes
3.5	Palpitations / irregular heartbeat	☐ No ☐ Yes	**3.15**	Neck, back or limb disorders	☐ No ☐ Yes
3.6	Abnormal shortness of breath	☐ No ☐ Yes	**3.16**	Double vision, difficulty seeing	☐ No ☐ Yes
3.7	Diabetes	☐ No ☐ Yes	**3.17**	Colour blindness	☐ No ☐ Yes
3.8	Head injury, spinal injury	☐ No ☐ Yes	**3.18**	Hearing loss or deafness or had an ear operation or use a hearing aid	☐ No ☐ Yes
3.9	Seizures, fits, convulsions, epilepsy	☐ No ☐ Yes	**3.19**	A psychiatric illness or nervous disorder	☐ No ☐ Yes
3.10	Blackouts or fainting	☐ No ☐ Yes			

Health professional's comments:

4.	Have you ever had any other serious injury, illness, disability, operation or accident or been in hospital for any reason? (please describe).	☐ No ☐ Yes

Health professional's comments:

5. Sleep

5.1	Have you ever been tested for a sleep disorder or been told by a doctor that you have a sleep disorder, sleep apnoea or narcolepsy?	☐ No ☐ Yes
5.2	Has anyone told you that your breathing stops or is disrupted by episodes of choking during your sleep?	☐ No ☐ Yes

5.3	How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? *This refers to your usual way of life in recent times. If you haven't done some of these things recently try to work out how they would have affected you.*	would never doze off **(0)**	slight chance of dozing **(1)**	moderate chance of dozing **(2)**	high chance of dozing **(3)**
a	Sitting and reading	☐	☐	☐	☐
b	Watching TV	☐	☐	☐	☐
c	Sitting inactive in a public place (e.g. a theatre or a meeting)	☐	☐	☐	☐
d	As a passenger in a car for an hour without a break	☐	☐	☐	☐
e	Lying down to rest in the afternoon when circumstances permit	☐	☐	☐	☐
f	Sitting and talking to someone	☐	☐	☐	☐
g	Sitting quietly after a lunch without alcohol	☐	☐	☐	☐
h	In a car, while stopped for a few minutes in the traffic	☐	☐	☐	☐

Health professional's comments:

6. Alcohol

6.1 Have you ever sought assistance for alcohol or substance use issues? ☐ No ☐ Yes

6.2	**Please circle the answer that best describes your situation.**	**(0)**	**(1)**	**(2)**	**(3)**	**(4)**
a	How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times per month	2 to 3 times per week	4 or more times per week
b	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
c	How often do you have six or more drinks on one occasion?	Never	Monthly or less	2 to 4 times per month	2 to 3 times per week	4 or more times per week
d	How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Monthly or less	2 to 4 times per month	2 to 3 times per week	4 or more times per week
e	How often during the last year have you failed to do what was normally expected from you because of drinking?	Never	Monthly or less	2 to 4 times per month	2 to 3 times per week	4 or more times per week
f	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	Monthly or less	2 to 4 times per month	2 to 3 times per week	4 or more times per week
g	How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Monthly or less	2 to 4 times per month	2 to 3 times per week	4 or more times per week
h	How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Monthly or less	2 to 4 times per month	2 to 3 times per week	4 or more times per week
i	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
j	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

Health professional's comments

Other

7.	Do you currently use illicit drugs?	☐ No ☐ Yes
8.	Do you use any drugs or medications not prescribed for you by your doctor?	☐ No ☐ Yes
9.	Have you been in a vehicle crash since your last fitness to drive examination?	☐ No ☐ Yes

Health professional's comments

Driver's declaration – accuracy and completeness of information provided

To the best of my knowledge the answers given above are accurate and complete:

Signature of driver

Date

Signature of examining doctor

Date