CERTIFICATE OF FITNESS
LIGHT VEHICLE (PRIVATE) DRIVERS LICENCE CLASSES C, RDATE, R, LR

Government of South Australia
Department for Infrastructure and Transport

MR712 09/20

Driver's Licence No: ☐☐☐☐☐☐

Class of Licence: ☐☐ ☐☐

Due Date: ☐☐/☐☐/☐☐☐☐

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

Surname _____

Given names _____ Date of birth _____

Home address _____

Suburb/Town _____ Postcode _____ Daytime phone no _____

Postal address if different from above _____

Email address (if available) _____

I have made the medical practitioner completing this form aware of any medical condition that I have and drugs or medication that I use. I consent to my medical practitioner and/or my treating specialist releasing to the Department for Infrastructure and Transport any medical information relating to my ability to drive safely.

Signature _____ Date _____

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

Please note: Your medical practitioner has a legal obligation to inform the Registrar if they believe that a person they have examined is suffering from a medical condition such that they may endanger the public if they drove.

SECTION 2: 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. Please:

- refer to the National Transport Commission's publication "Assessing Fitness to Drive 2016" private standards for light vehicle licence. The guidelines are available from Austroads at www.austroads.com.au (your assessment must be undertaken in accordance with the guidelines);
- please complete all of sections 3 and 5;
- please complete section 4 if your patient has a vision or eye disorder, or is required to wear glasses or corrective lenses;
- provide comment in the notes section on the inner page 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

ISMF Classification when complete - SENSITIVE: MEDICAL - I3 - A3

SECTION 3: MEDICAL EXAMINATION REPORT - For all "Yes" answers provide comments on the page opposite.

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. HEARING LOSS

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

6. 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
- ☐ Other Musculoskeletal Conditions
- ☐ Limb _____

7. 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
- ☐ Seizure
  Date of last episode: __ / __ / __
- ☐ Space-occupying Lesion (brain tumour)
- ☐ Stroke
  Date of last episode: __ / __ / __
- ☐ Subarachnoid Haemorrhage
  Date of last episode: __ / __ / __
- ☐ Other (please specify)

_____

8. PSYCHIATRIC CONDITION

Does your patient have a <u>severe</u> 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
- ☐ Personality Disorder
- ☐ Post Traumatic Stress Disorder (PTSD)
- ☐ Schizophrenia
- ☐ Tourette's Syndrome
- ☐ Other: _____

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

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

9. SLEEP DISORDER

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

If Yes, please complete the following.

- ☐ Established Sleep Apnoea Syndrome
- ☐ Narcolepsy
- ☐ Other: _____

10. SUBSTANCE MISUSE

Does your patient currently misuse alcohol or drugs? ☐ No ☐ **Yes**

If yes, complete the following.

- ☐ Alcohol
- ☐ Illicit drugs
- ☐ Prescription drugs

SECTION 4: EYESIGHT CERTIFICATE

(Only complete questions 11 and 12 if your patient has a vision or eye disorder, or is required to wear glasses or corrective lenses)

11. Does your patient have one or more of the following vision or eye disorders? Please tick:

☐ Diplopia ☐ Monocular Vision ☐ Visual Field Defect ☐ Retinitis Pigmentosa

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 vision or eye disorder which may impair their ability to drive (please specify) _____

_____

12. **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 2016 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:

_____

_____

_____

_____	_____	____ /____ /____
Medical Practitioner name	Optometrist/Ophthalmologist name	Date
_____	_____	_____
Signature	Signature	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 your patient is suffering from a physical or mental illness, disability or deficiency that is likely to endanger the public if your patient drives a motor vehicle.

If you consider it prudent you may recommend that your patient undertakes a practical driving assessment. This is irrespective of your 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 to retain the additional licence class.

If you consider that your patient may be unfit to drive, please immediately return the completed certificate to **Locked Bag 700, Adelaide SA 5001. Information may be immediately faxed to 8402 1977.**

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

MEDICAL PRACTITIONER'S DECLARATION

This 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	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. If the applicant holds a 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

_____

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.