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 the patient may be unfit to drive, please return this completed certificate to **Locked Bag 700, Adelaide SA 5001. Information may be faxed to 8402 1977.**

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

On _____ /_____ /_____ I examined _____
(date of examination) *(patient's name)*

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
If No, please provide details below:

_____
_____

Requires a practical driving test? ☐ No ☐ Yes

Should be issued a licence subject to conditions? ☐ No ☐ Yes
If Yes, please provide details below

_____
_____
_____
_____

I certify that I personally examined the above named patient in accordance with the Assessing Fitness to Drive guidelines.

_____ _____/_____/_____
Medical Practitioner's name *Date*

_____ _____ _____
Medical Practitioner's signature *Provider Number* *Telephone Number*

_____ _____
Practice Address *Facsimile Number*

ADDITIONAL NOTES: Please provide comment to each YES answer in the medical/eyesight examination, including reference to the specific condition (e.g. 4. Diabetes).

_____
_____
_____
_____
_____
_____
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_____

SELF ASSESSMENT

FOR C (CAR) CLASS LICENCE HOLDERS

Government of South Australia
Department of Planning, Transport and Infrastructure

MR1562 04/15

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/or Eyesight Examination (PART B and C) prior to returning the form.

If you require assistance please call 13 10 84 or contact a Service SA Customer Service Centre.

Yours sincerely,

Julie Holmes
REGISTRAR OF MOTOR VEHICLES

YOU ARE REQUIRED TO EITHER:

- Complete the self assessment online via EzyReg, located at sa.gov.au/ezyreg/selfassessment

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.
Penalties apply for providing false or misleading information.

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 disorder? *(e.g. chronic depression, anxiety disorder, 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 condition? *(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 may see an optometrist to have PARTS C and D only completed.

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 if you want the 'S' condition removed — you must take this form to a medical practitioner and have them complete PARTS C and D.

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.

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

MEDICAL PRACTITIONER ONLY TO COMPLETE PARTS B AND C

PART B: MEDICAL EXAMINATION

Only complete if person has answered YES or UNSURE to one or more questions 1 - 9 in the 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 DISEASE
Does the patient have, or has had a cardiovascular condition? ☐ No ☐ **Yes**
If Yes, please complete the following.
Please tick the appropriate condition(s):
☐ Acute Myocardial Infarction ☐ Coronary Artery Bypass Grafting (CABG)
☐ Angina (If Unstable) ☐ Heart Failure
☐ Cardiac Aneurysm ☐ Heart Transplant
☐ Cardiac Arrest ☐ Hypertrophic Cardiomyopathy
☐ Cardiac Pacemaker ☐ Implantable Cardioverter Defibrillator
☐ Congenital Heart Disorder ☐ Percutaneous Coronary Intervention (Angioplasty)
☐ Dilated Cardiomyopathy
☐ Other Cardiovascular: _____

3. HYPERTENSION
Does the 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 the patient have diabetes controlled by medication? ☐ No ☐ **Yes**
If Yes, please complete the following.
Diabetes controlled by ☐ Insulin ☐ Tablet
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. MUSCULOSKELETAL DISORDER
Does the patient have a musculoskeletal disorder? ☐ No ☐ **Yes**
If Yes, please complete the following.
Please tick the appropriate condition(s):
☐ Arthritis ☐ Limb
☐ Other Musculoskeletal Disorders _____
Is the condition likely to affect driving? ☐ No ☐ **Yes**

6. NEUROLOGICAL / NEUROMUSCULAR CONDITIONS
Does the patient have a neurological / neuromuscular condition? ☐ No ☐ **Yes**
If Yes, please complete the following.
Please tick the appropriate condition(s):
☐ Brain Aneurysm ☐ Muscular Dystrophy
☐ Cerebral Palsy ☐ Parkinson's Disease
☐ Dementia ☐ Seizures*
☐ Epilepsy* ☐ Space-occupying Lesion (incl. brain tumour)
☐ Head Injury ☐ Stroke*
☐ Intellectual Impairment ☐ Subarachnoid Haemorrhage*
☐ Meniere's Disease ☐ Vertigo
☐ Multiple Sclerosis ☐ Other: _____

*Date of last episode: _____ /_____ /_____

7. PSYCHIATRIC DISORDER
Does the patient have a mental health/nervous disorder? ☐ No ☐ **Yes**
If Yes, please complete the following.
Please tick the appropriate condition(s):
☐ Anxiety Disorder ☐ Post Traumatic Stress Disorder (PTSD)
☐ Bipolar Affective Disorder ☐ Schizophrenia
☐ Chronic Depression ☐ Tourette's Syndrome
☐ Personality Disorder ☐ Other: _____
Does the patient require medication? ☐ No ☐ **Yes**
If Yes - is the patient compliant with medication? ☐ No ☐ **Yes**

8. SLEEP DISORDER
Does the patient have a sleep disorder? ☐ No ☐ **Yes**
If Yes, please complete the following.
☐ Established Sleep Apnoea Syndrome
☐ Narcolepsy ☐ Other: _____

9. SUBSTANCE MISUSE
Does the patient 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): _____

PART C: EYESIGHT EXAMINATION

If the person has answered YES or UNSURE to question 10 only, only PART C needs to be completed, otherwise PART B and C must be completed.

10. Does the patient have any of the following eye or vision conditions? ☐ No ☐ **Yes**
If Yes, please complete the following.
Please tick the appropriate condition(s):
☐ Cataracts ☐ Visual Field Defect
☐ Macular Degeneration ☐ Glaucoma
☐ Retinitis Pigmentosa ☐ Poor Night Vision
☐ Diplopia
☐ 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 Examination.
Additionally, if the patient's visual acuity with corrective lenses in the better eye or with both eyes together is worse than 6/12, 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 Examination.

Does the patient have Monocular Vision? ☐ No ☐ **Yes**
If Yes, the eyesight Examination 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 guidelines? ☐ No ☐ **Yes**
Are glasses or contact lenses required for driving? ☐ No ☐ **Yes**
Please provide any additional information below.
If you are not completing PART B of this form please provide your details.

_____ _____ /_____ /_____
Medical Practitioner's name *Date*

_____ _____ _____
Medical Practitioner's signature *Provider Number* *Contact Number*

Please provide comment to each YES answer on the page overleaf under ADDITIONAL NOTES.