



WYOMING DEPARTMENT OF TRANSPORTATION

Driver Services
5300 Bishop Blvd.
Cheyenne, WY 82009-3340
Phone: 777-4821 Fax: 777-3823

DRIVER MEDICAL EVALUATION

NAME (As appears on driver license) DATE OF BIRTH DRIVER LICENSE NUMBER

MAILING ADDRESS CITY STATE ZIP

Dear Doctor: Driver Services requests your assistance in determining the medical, physical and/or mental condition of your patient. Although the Department seeks the benefit of your judgment about medical fitness to drive safely, you are neither expected nor required to make the decision about your patient's driver license. This legal responsibility rests entirely with the Driver Services program, which must also take into account considerations other than medical. We know you share our concern for the safety of your patient, as well as the safety of the public on our roadways. We appreciate your time and cooperation in completing this form. You need only fill out those areas which you feel are pertinent to your patient. Any charges for completion of this form should be made to your patient.

(Type or Print Legibly)

1. How long has this person been your patient? Date of last examination:

2. DIAGNOSIS: How long has the condition(s) existed?

Blood Pressure Reading (if hypertensive or hypotensive): Is patient's blood pressure controlled? Yes No

Principle symptoms/limitations:

EPILEPSY/SEIZURE DISORDER: Yes No If yes, please give details:

Type of seizure: Generalized Psychomotor Grand Mal Petit Mal Other:

Frequency/duration of aura Diurnal Nocturnal

DIABETES: Yes No If yes, please give details:

Insulin Dependent Non-Insulin Dependent Retinopathy Neuropathy Polyneuropathy

ALCOHOL/DRUG ADDICTION: Yes No If yes, please give details:

Loss of consciousness Other:

Date and duration of last alcohol/drug free period:

Treatment?

None Needed Alcohol/Drug Rehabilitation Program Completed Alcohol/Drug Rehabilitation Recommended

3. The stated medical condition is likely to result in episodes of: Dizziness Loss of muscular/physical control Confusion Unconsciousness Severe pain Irrational behavior

Number of episodes within the past two (2) years Date of last episode:

4. Is your patient's overall medical condition likely to deteriorate within the next 12 months? Yes No

MEDICATION/DRUGS

5. Does your patient routinely take prescribed medication or drugs? " Yes " No

List any side effects your patient is experiencing from medication: _____

Has your patient's condition remained controlled by medication for at least three (3) months? " Yes " No

IN MY PROFESSIONAL OPINION:

- " The condition(s) stated above does not substantially impair a person's ability to exercise ordinary and reasonable control of a motor vehicle.
- " My patient is medically capable of *safely* operating a private automobile, but not a commercial vehicle.
- " My patient is medically capable of *safely* operating any motor vehicle, but only under a prescribed medical regimen.
- " My patient is **NOT** " medically " physically " mentally capable of *safely* operating a motor vehicle.
- " The condition(s) described herein no longer exists.

RECOMMENDATIONS:

- " Independent medical evaluation from a specialist in another medical field for the purpose of determining driving safety.
Type of evaluation recommended: _____
- " Driving test by a driver examiner to determine driving safety.
- " Recommended restrictions for the driver license:
 - " Annual Medical Evaluation " Daylight Driving Only " Specific Limits of Time/Distance _____
 - " No Interstate Driving " Outside Mirrors " Special Adaptive Devices/Equipment: _____
 - " Automatic Transmission " Prosthetic Aide " Other: _____

REMARKS/COMMENTS:

Physician's Name (printed) Physician's Signature Date Signed

Classification/Specialty Address City State Zip Code Phone Number