Transport for NSW

Medical Assessment for Public Passenger Vehicle Drivers

Customer details

Given name(s)

Surname

Date of Birth

day / month / year

Gender

Male ☐ Female ☐

Licence number

Residential address (PO box not accepted)

Postcode

Contact phone number

Email address

Information for customers

This assessment from your medical practitioner will help us decide whether to grant, renew, suspend or cancel your driver licence or impose licence conditions. You must sign this document on page 3 to declare that the statements made to your doctor are true and complete.

Your responsibility as a driver

You are legally required to advise Transport for NSW of any long-term injury or illness that may affect your ability to drive safely. Penalties apply if you fail to report these to us. You may be legally liable if you continue to drive, knowing you have a condition that could adversely affect your driving.

Information for health professionals

We are asking you to complete this medical assessment so your patient can apply for or keep their NSW Driver Licence.

You can complete the assessment:

- online at **au.healthlink.net** where it will be sent electronically to Transport for NSW, or
- by filling out this form and asking your patient to take it to a Service NSW centre where it will be processed.

Only information relevant to your patient's fitness to drive should be listed in this assessment. Where medical fitness cannot be determined please refer the patient to an appropriate specialist.

The 'Reason for medical' indicates whether the patient requires a private or commercial licence. They must meet the Assessing Fitness to Drive medical standards that are available at **austroads.com.au**

Commercial drivers may require specialist medical review in accordance with Assessing Fitness to Drive medical standards.

Important - Health professionals must adhere to the Assessing Fitness to Drive medical standards when recommending conditional licences. Recommendations that conflict with these standards and/or Transport for NSW medical review and licensing schemes may not be implemented.

Privacy statement

Personal and Health information is managed by Transport for NSW in accordance with the *Privacy and Personal Information Protection Act 1998* and the *Health Records and Information Privacy Act 2002*. Transport for NSW collects personal information in connection with the fitness to drive assessment. Transport for NSW cannot accept the assessment unless the applicant and health professional provide this information. We may retain, use, and disclose the personal information in connection with verifying the applicant's identity and their assessment.

For more information about how Transport for NSW manages personal information, please visit **transport.nsw.gov.au** or phone **13 22 13** to request a copy of our privacy statement.

To access or amend your personal information please use the access and amendment application forms available at **transport.nsw.gov.au**

Sections 1, 2 and 3 must be completed for ALL patients. If the patient has a vision, eye disorder or a visual field defect an optometrist or ophthalmologist must complete these sections. Complete all other sections, indicating medical conditions where appropriate.

1. Vision - Does the patient have a vision or eye disorder? ☐ Yes ☐ No

If yes, please tick the condition(s)

☐ Cataracts ☐ Diplopia/Double vision ☐ Diabetic Retinopathy ☐ Monocular vision
☐ Glaucoma ☐ Poor night vision ☐ Macular degeneration
☐ Other, specify: ____
☐ Tick if the condition(s) indicated above is corrected by wearing glasses or contacts.

2. Vision - What is the patient's visual acuity?

	Right	Left	Together
List Visual Acuity uncorrected	6/_____	6/_____	6/_____
List Visual Acuity with glasses/contacts	6/_____	6/_____	6/_____

3. Vision - Does the patient have a restricted visual field or a visual field defect? ☐ Yes ☐ No

Does the patient's binocular visual field meet at least 110 degrees for a private class of licence or 140 degrees for a commercial class licence within 10 degrees above and below the horizontal midline with no significant vision loss as per Assessing Fitness to Drive? ☐ Yes ☐ No

If no, specify: ____

Optometrist or ophthalmologist details. Complete only if relevant.

Name: ____ **Date:** ____

Signature: ____ **Tel No:** ____

4. Cardiovascular Disease - Does the patient have a cardiovascular condition(s)? ☐ Yes ☐ No

If yes, please tick the condition(s).

☐ Acute Myocardial Infarction ☐ Angina (unless absent on mild exertion) ☐ Anticoagulant Therapy
☐ Atrial Fibrillation ☐ Complicated Congenital Disorders ☐ Coronary Artery Bypass Grafting
☐ Dilated Cardiomyopathy ☐ Heart Failure ☐ Heart Transplant
☐ Pacemaker ☐ Hypertrophic Cardiomyopathy ☐ Implantable Cardiac Defibrillator (ICD)
☐ Valvular Heart Disease ☐ Paroxysmal Arrhythmias ☐ Percutaneous Coronary Intervention (PCI)
☐ Hypertension ☐ Vasovagal Syncope ☐ Ventricular Assist Devices (VAD)
☐ Cardiac Arrest ▶ Date ____

☐ Aneurysms ▶ Specify size ____
▶ ☐ Tick if repaired
▶ ☐ Tick if the aneurysm is associated with atherosclerosis or bicuspid aortic valve

☐ Other ____

5. Diabetes - Does the patient have diabetes? ☐ Yes ☐ No

If yes, indicate treatment:

☐ Insulin ☐ Tablets/other non insulin agents ☐ Diet only
☐ Tick if patient is **not** compliant with treatment
☐ Specify any end organ effects ____

6. Epilepsy or seizures - Does the patient have epilepsy or has experienced a seizure? ☐ Yes ☐ No

If yes, specify type: ____ ▶ Date of last two seizures: (a) ____ (b) ____
☐ Tick if a diagnosis of epilepsy has been confirmed Date medication ceased, if applicable: ____

7. Neurological condition - Does the patient have Dementia or other cognitive impairment? ☐ Yes ☐ No

If yes, specify: ____ ▶ ☐ Tick if specialist referral is required.

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8. Neurological condition - Does the patient have vestibular, neurological or other neurodevelopmental disorders? ☐ Yes ☐ No

☐ Aneurysms (unruptured intracranial) ☐ Blackout: Date of most recent episode:__________

☐ Brain tumour(s) ☐ Cerebral Palsy ☐ Head/Brain injury ☐ Intellectual impairment

☐ Meniere's Disease ☐ Multiple Sclerosis ☐ Parkinson's ☐ Vertigo

☐ Neuromuscular Condition

☐ Stroke: Date of most recent episode:__________ Other, specify:__________

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9. Sleep Disorder - Does the patient have established sleep apnoea syndrome, narcolepsy, or excessive sleepiness? ☐ Yes ☐ No

If yes, please tick the condition(s)

☐ Narcolepsy ☐ Sleep Apnoea Syndrome

☐ Other, specify:__________

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10. Psychiatric condition -
Does the patient have a chronic psychiatric condition of such severity that may impact safe driving? ☐ Yes ☐ No

If yes, tick the condition(s)

☐ Anxiety disorder ☐ ADHD ☐ Bipolar affective disorder ☐ Chronic Depression

☐ Personality disorder ☐ PTSD ☐ Schizophrenia ☐ Tourettes

☐ Psychogenic nonepileptic seizures: ▶ Date __________ ☐ Other, specify:__________

☐ Tick if the patient requires medication for any of the above conditions

☐ Tick if the patient is **not** compliant with medication

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11. Musculoskeletal disorder - Does the patient have a musculoskeletal disorder? ☐ Yes ☐ No

If yes, please tick the condition(s)

☐ Chronic pain ☐ Severe arthritis ☐ Other, specify: __________

☐ Deformities ▶ Specify:__________

☐ Loss of digits ▶ Specify:__________

☐ Loss of limbs ▶ Specify:__________ ▶ ☐ Left ☐ Right

☐ Tick if the patient requires vehicle modifications

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12. Substance use disorder - Does the patient have a substance use disorder? ☐ Yes ☐ No

If yes, complete the following

Is there alcohol dependence or heavy frequent alcohol use? ☐ Yes ☐ No

Is there a substance use disorder such as dependence or other use likely to affect safe driving? ☐ Yes ☐ No

Does the patient have an absence of cognitive impairments and end organ effects? ☐ Yes ☐ No

Is the patient in a treatment program and in remission (the patient is **not fit** to drive until they meet this criteria)? ☐ Yes ☐ No

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13. Medications - Is the patient taking multiple medications that may affect driving? ☐ Yes ☐ No

If yes, specify effects on driving __________

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14. Hearing loss (for commercial drivers only)

Does the patient have severe hearing loss? ☐ Yes ☐ No

Is the standard able to be met with hearing aid? ☐ Yes ☐ No

Declaration and consent

I declare I have provided true and complete details to my medical practitioner. I consent to my medical practitioner providing my health and information to Transport for NSW, or to a medical practitioner nominated by Transport for NSW. Further, I give authority to Transport for NSW to obtain details of any matter which may assist in determining whether I meet the medical criteria outlined in the publication 'Assessing Fitness to Drive' (Commercial and Private Vehicle Drivers).

Signature: __________ **Date:** __________

Doctor or Medical Specialist Certification

This section must be completed by a health professional

How long have you treated the patient? List years / months ___ Y ___ M

How long has the patient been with this practice? List years / months ___ Y ___ M

Did you have knowledge of the patient's medical history before undertaking this assessment? ☐ Yes ☐ No

Note: if you ticked no, request the patients medical file to complete the assessment according to the Assessing Fitness To Drive medical standards on **austroads.com.au**

Any additional comments on conditions likely to affect driving? ☐ Yes ☐ No

If yes, please detail below and attach supplementary documents

Recommendations

In my opinion, the patient of this assessment:

☐ **Option 1:** Meets the medical criteria for an unconditional licence (note, drivers aged 75+ require periodic medical review)

☐ **Option 2:** Meets the medical criteria for a conditional licence, subject to periodic medical review, downgrade of licence class or further assessment (indicate restrictions if applicable)

Review Period (required)

☐ Transport for NSW default review ☐ Other, specify: ____________________

Downgrade to a lower class of licence (if applicable)

☐ Specify class ____________________(confirm if rider licence can be maintained if applicable)

Further assessment (if applicable)

☐ Transport for NSW driving test (competency to drive needs to be assessed)

☐ Occupational therapist practical driving assessment

☐ Review by a specialist - Specify: ____________________

Recommended licence conditions (if applicable)

☐ Daylight hours only

☐ Modified vehicle - Specify: ____________________

☐ Radius restriction.

Specify distance: ☐ 2km ☐ 5km ☐ 10km ☐ 15km ☐ 20km ☐ 30km ☐ 40km ☐ 50km ☐ 75km ☐ 100km

☐ **Option 3:** Does not meet the medical criteria for an unconditional or conditional driver licence

☐ Permanently does not meet the medical criteria

☐ Temporarily does not meet the medical criteria

Date: ____________________

Doctor's name: ____________________ Signature: ____________________

Field of Practice and Registered number: ____________________

Address: ____________________

____

Tel No: ____________ Fax No: ____________ Email: ____________________

Office use only

CSR signature	Staff number	Centre name	Date	Customer licence no.

Vision section completed or tested at Service NSW ☐ Yes ☐ No

Vision meets standards ☐ Yes ☐ No

Satisfactory report - no further adjudication required ☐ Yes ☐ No

Report referred to Licence Review Unit for adjudication ☐ Yes ☐ No

If yes, reason why: ____________________

(eg failed result, new medical declaration, expiring a medical condition code, specialist review, driving test, etc)

Note: If new licence conditions have been recommended by the doctor, ensure they are recorded and arrange for a replacement licence to be issued. Do not refer these medicals to Licence Review Unit unless further adjudication is required.

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