

# Driver Licence Medical

Surname

Given Name(s)

Address

Contact Number

Date of Birth

**Privacy Statement:** The information sought on this form is to assess your compliance with the required medical standards. The lawful authority for collecting this information is the *Road Transport (Driver Licensing) Regulation 2000*. The information may be disclosed to Commonwealth, Territory or State law enforcement agencies; transport authorities in those jurisdictions; and government agencies authorised by law. The information may also be disclosed to medical professionals and driving assessors only as is needed to assess your ability to drive safely.

You can complete your details above and email this form to your chosen medical practitioner who can complete the details below electronically. You will need to contact the medical practice to obtain their email address.

## Examination to be completed by a Medical Practitioner

The examination must be conducted in accordance with the national medical standards described in 'Assessing Fitness to Drive'. This publication is available from the ACT Road Transport Authority or via the website at [www.austroads.com.au](http://www.austroads.com.au)

How long have you treated the patient / how long has the patient attended this medical practice? \_\_\_\_\_

Do you know the medical history of the patient?  Yes  No

This application applies to:  A New Licence Application  An Existing Licence (include number) \_\_\_\_\_

The Licence Class for this application is:

Motorcycle  Car  Light Rigid Vehicle (vehicle up to 8 tonne GVM)

**Visual Acuity** - please specify

Both  6/  Right  6/  Left  6/

**Was eye test conducted with corrective lenses?**

Yes  No

**Note: Eye test results and confirmation (yes or no) to corrective lenses must be recorded or the medical WILL NOT be accepted.**

Does the patient have any of the following conditions? Please tick all boxes that apply. A tick indicates a positive response.	Does this affect his or her ability to drive?	Is a driving assessment or review required by a medical specialist?
<b>Cardiovascular problems</b> Please specify _____ <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Assessment: <input type="checkbox"/> Yes <input type="checkbox"/> No Review: <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Diabetes</b> <input type="checkbox"/> Insulin dependent <input type="checkbox"/> Tablets <input type="checkbox"/> Dietary           _____ <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Assessment: <input type="checkbox"/> Yes <input type="checkbox"/> No Review: <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Epilepsy</b> Date of last attack ____ / ____ / ____ <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Assessment: <input type="checkbox"/> Yes <input type="checkbox"/> No Review: <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Mental / Psychiatric disorder</b> Please specify _____ <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Assessment: <input type="checkbox"/> Yes <input type="checkbox"/> No Review: <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Muscular / Skeletal disorders</b> Please specify _____ <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Assessment: <input type="checkbox"/> Yes <input type="checkbox"/> No Review: <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Neurological disorder</b> Please specify _____ <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Assessment: <input type="checkbox"/> Yes <input type="checkbox"/> No Review: <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Visual problems</b> Please specify _____ <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Assessment: <input type="checkbox"/> Yes <input type="checkbox"/> No Review: <input type="checkbox"/> Yes <input type="checkbox"/> No

Does the patient have any of the following conditions? Please tick all boxes that apply. A tick indicates a positive response.	Does this affect his or her ability to drive?	Is a driving assessment or review required by a medical specialist?
<b>The applicant is on medication which would adversely affect his / her ability to drive</b> (please list) <input type="checkbox"/> _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Assessment: <input type="checkbox"/> Yes <input type="checkbox"/> No Review: <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Other</b> <input type="checkbox"/> E.g. Excessive use of alcohol and drugs, blackouts, dizziness or metabolic / endocrine, hearing, liver, renal, respiratory, sleep, syncope and / or vestibular disorders. Please specify _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Assessment: <input type="checkbox"/> Yes <input type="checkbox"/> No Review: <input type="checkbox"/> Yes <input type="checkbox"/> No

### Medical Practitioner to Complete

I certify that I have examined the afore mentioned patient in accordance with the National Medical Standards (Private) as set out in 'Assessing Fitness to Drive'. In my opinion the person subject of this report:

#### Medical Opinion

#### Action Required

<input type="checkbox"/> <b>Meets</b> the relevant medical criteria for an unconditional licence. _____ _____	<b>If no further medicals are required</b> , indicate reasons in the box provided.
<input type="checkbox"/> <b>Does not meet</b> the medical criteria for an unconditional or a conditional licence. _____ _____	Examining doctor to clearly note in the box provided: 1) <b>Criteria not met</b> and other relevant medical details
<input type="checkbox"/> <b>Does not meet</b> the medical criteria for an unconditional licence but may be suitable for a conditional licence based on opinion below and additional details attached as required. _____ _____ _____	Examining doctor to clearly note in the box provided: 1) <b>Criteria not met</b> and other relevant medical details. 2) <b>Proposed restrictions</b> to licence (if appropriate). 3) Suggestions for <b>management and periodic review interval (conditional licence)</b> .
<input type="checkbox"/> Specialist report was obtained and is attached / summarised below. _____ _____ _____	Examining doctor to obtain required information from specialist and attach report or summarise findings.
<input type="checkbox"/> Requires practical driving test and is medically and psychologically fit to undertake a test. _____ _____	Examining doctor to clearly note in the box provided, details regarding the medical condition as relevant to the driving task.
<input type="checkbox"/> Requires occupational therapist assessment and is medically and psychologically fit to undertake an occupational therapist assessment. _____ _____	Examining doctor to clearly note in the box provided, details regarding the medical condition as relevant to the driving task.
<input type="checkbox"/> Requires an assessment by the Fitness to Drive Medical Clinic. _____ _____	Examining doctor to clearly note in the box provided, details regarding the medical condition as relevant to the driving task.

### Medical Practitioner Details

Name of Examining Doctor (please print or stamp)	Signature	Date of examination
Address	Telephone	

## Information for Licence Applicants and Licence Holders

**The completed Driver Licence Medical must be presented to Road User Services prior to the due date** (please allow sufficient time for any medical examinations / assessments etc.) **in order to obtain an original licence or avoid suspension of your current licence.**

The completed Driver Licence Medical can be submitted by mail to **P.O Box 582 Dickson ACT 2602** or emailed to **rusmedicals@act.gov.au** or faxed to **(02) 6207 7120**.

This Driver Licence Medical is valid for six months from the date of issue. Road User Services does not acknowledge the return of medical assessment reports. If there is a problem with the report or the report is not received by the due date, you will be contacted.

### **Medical Examination requirements for holders of an ACT Driver Licence**

Applicants in the following categories are required to undergo a medical examination prior to the issue of a licence and thereafter as outlined below.

**People 75 years of age or over** are required to be examined annually by their own doctor.

**People with Diabetes** are required to be examined by their own doctor as follows:

#### **For licence classes R, C and LR**

<b>Insulin dependent:</b>	Medical every 2 years
<b>Tablets:</b>	Medical every 5 years
<b>Diet:</b>	No medical required

**People with Epilepsy** are required to be examined annually by their own doctor. However, should they be seizure free and off medication for an extensive period, their doctor may recommend them as safe to have the indicator removed from their licence record. If a person with epilepsy has a seizure at any time, they should see their doctor prior to recommencing driving.

**People with heart condition / disease** before commencing or recommencing driving after the onset of a condition, are required to take this medical form to their General Practitioner who will determine whether he or she can assess their fitness to drive, or whether they will need to be assessed by a specialist, e.g. a Cardiologist. Thereafter an annual examination with their General Practitioner is required unless otherwise specified on the medical.

**People with other disabilities** (paralysis, amputees, etc.) are required to undergo a medical examination with their General Practitioner before recommencing driving after the onset of a condition.

**Should you wish to apply for an internal review** of the Road Transport Authority's decision to send you for a medical, applications for review should be addressed to: The Manager, Road User Services, PO Box 582 Dickson, ACT 2602. An application for internal review must be made within 28 days of receiving this letter.

If you are dissatisfied with the outcome of the internal review, you have the right to apply to the ACT Civil and Administrative Tribunal (ACAT) to review the decision of the internal review. An application to the ACAT can only be made following an internal review.

Applications to the ACAT must be made within 28 days of the date of the decision of the internal review. Please note that an application fee may apply. Applications should be sent to: ACT Civil and Administrative Tribunal, Level 4, 1 Moore St, Canberra ACT 2600. Phone (02) 6207 1740.

For further enquiries - in the first instance telephone Canberra Connect on 13 22 81. You can change your address online at [www.rego.act.gov.au](http://www.rego.act.gov.au).

### **For Medibank Health Solutions (MHS) medical examinations you must make an appointment by phoning 6269 2001.**

A consultation fee will apply. The MHS office is located on the first floor of Health Services Australia House, 15 Bowes Street, Woden ACT. Two (2) working days notice must be given to MHS if you intend to change or cancel the appointment. Failure to do so may result in you being charged for the amount of the consultation.