Medical Assessment of Fitness to Drive for Commercial Drivers

Please read the detailed medical assessment instructions for the applicant and Medical Practitioner. This form may be submitted to Main Roads Western Australia (MRWA) via email to pilots@mainroads.wa.gov.au, fax on (08) 9475 8455, or post to Main Roads Heavy Vehicle Services **PO Box 374 WELSHPOOL DC WA 6986.** Please mark as **"Confidential"**

Applicant details - to be completed by applicant

FAMILY NAME:	DRIVER'S LICENCE NO:	EXPIRY DATE:
GIVEN NAMES:		DATE OF BIRTH:
RESIDENTIAL ADDRESS:		

I consent to any reporting Medical Practitioner named on this form releasing information to Main Roads Western Australia and Main Roads Western Australia contacting any reporting Medical Practitioner named on this form to obtain any further information relevant to my fitness to drive.

SIGNATURE

REASON FOR REFERRAL

APPLICANT HAS DECLARED THAT:

HE/SHE SUFFERS FROM

HE/SHE TAKES AS MEDICATION

Enquiries 138 486

Assessment of Fitness to Drive - to be completed by Medical Practitioner

Please answer all questions below:

1. Were you familiar with the patient's medical history prior to this examination? ☐ Yes ☐ No

2. I have attended this patient professionally since: _____ (Month/Year)

Visual Acuity:

☐ Uncorrected			☐ Corrected		
R	L	B	R	L	B
6/	6/	6/	6/	6/	6/

Blood Pressure Reading _____

Other Medical Condition _____

3. Clinical Findings
Please provide where applicable

- details of medical condition
- treatments
- history of episodes
- details of control or complication/s
- conditions of licence
- results of relevant investigations e.g. Hba1c for diabetes

4. In my opinion the person who is the subject of this report:

a. ☐ **Meets the relevant medical criteria -** Fit to drive

b. ☐ **Does not meet the relevant medical criteria -** Not fit to drive
Criteria not met - (Please detail relevant clinical findings at question 3)

5. Requires specialist assessment ☐ Yes ☐ No Please specify _____

6. Recommended re-assessment period ☐☐ years ☐☐ months

7. I have discussed this recommendation with patient ☐ Yes ☐ No

8. I have examined the patient according to: ☐ **Commercial vehicle standards** (Heavy Vehicle Pilot)

DATE OF EXAMINATION	DATE OF REPORT	SURGERY STAMP
REPORTING PROFESSIONAL'S NAME AND QUALIFICATION		

I certify that I have examined the above-mentioned patient in accordance with the relevant National Medical Standards (private or commercial vehicle standards) as set out in *Assessing Fitness to Drive* Guidelines.

TELEPHONE	FAX	SIGNATURE	☐ FURTHER COMMENTS ON MEDICAL CONDITION(S) AFFECTING SAFE DRIVING ARE ATTACHED
EMAIL ADDRESS			