CERTIFICATE OF FITNESS
LIGHT VEHICLE (PRIVATE) DRIVERS
LICENCE CLASSES C, RDATE, R, LR

Government of South Australia
Department of Planning, Transport and Infrastructure

MR712 01/14

Driver's Licence No:

Class of Licence:

What to do with the completed certificate

- Return to GPO Box 1533, Adelaide 5001 or any Service SA Customer Service Centre
- Enquiries: 13 10 84

SECTION 1: YOUR DETAILS (to be completed in BLOCK letters prior to seeing your doctor)

Surname ____________________

Given names ____________________ Date of birth ____________________

Home address ____________________

Suburb/Town ____________________ Postcode __________ Daytime phone no ____________________

Postal address if different from above ____________________

Email address (if available) ____________________

1. Have you consulted any medical practitioner within the last 12 months that the medical practitioner completing this form does not know about? *Please provide the name of medical practitioner or treating specialist* ____________________

2. Please list all the medications that you take (prescribed or otherwise). *Attach list if necessary* ____________________

3. Have you been the driver of a vehicle involved in a crash in the last 5 years? Yes ☐ No ☐
   If Yes, please provide details ____________________

4. Is driving a significant part of your occupation or voluntary work (eg courier driver or community bus driver)? Yes ☐ No ☐
   If you answered "Yes", approximately how many hours per day do you drive? Hours: __________

I declare that to the best of my knowledge the above information is true and correct and that I have made the medical practitioner completing this form aware of any medical condition that I have and drugs or medication that I use.

Signature ____________________ Date ____________________

Please note: Your medical practitioner has a legal obligation to inform the Registrar if they believe that a person they have examined is suffering from a medical condition such that they endanger the public if they drove.

A person must not, in providing information, make a statement that is false or misleading. Penalties apply.

SECTION 2: IMPORTANT NOTES FOR THE MEDICAL PRACTITIONER

The Registrar of Motor Vehicles requires certain applicants for a driver's licence, or licence holders, to provide evidence of their fitness to drive. Please:

- refer to section 1 that has been completed by your patient;
- refer to the National Transport Commission "Assessing Fitness to Drive 2012" the 'guidelines' private standards for light vehicle licence. The guidelines are available from Austroads at www.austroads.com.au/images/stories/AFTD_reduced_for_web.pdf (your assessment must be undertaken in accordance with the guidelines);
- provide comment in the notes section on the opposite page, on how well controlled your patient's condition(s) are and compliance with any medication taking;
- section 4 (Eyesight Certificate) must be completed in all cases;
- if you are familiar with your patient's full medical history, you only need to complete the parts of section 3 relevant to the patient's medical conditions and all of sections 4 and 5;
- if you are not familiar with your patients full medical history please complete all of sections 3, 4 and 5

PRACTITIONER
SECTION 3: MEDICAL EXAMINATION REPORT - For all "yes" answers provide comments on the page opposite

1. BLACKOUT

Has your patient experienced a blackout? ☐ No ☐ **Yes**

(If No, go to Question 2. If Yes, please complete the following.)

Date of most recent episode: __ / __ / __

2. CARDIOVASCULAR DISEASE

Does your patient have a cardiovascular condition? ☐ No ☐ **Yes**

(If No, go to Question 3. If Yes, please complete the following.)

Please tick the appropriate condition(s):

☐ Acute Myocardial Infarction
☐ Angina
☐ Angioplasty
☐ Cardiac Aneurysm
☐ Cardiac Arrest
☐ Cardiac Pacemaker
☐ Congenital Heart Disorder
☐ Coronary Artery Bypass Grafting (CABG)
☐ Dilated Cardiomyopathy
☐ Heart Failure
☐ Heart Transplant
☐ Hypertrophic Cardiomyopathy
☐ Other Cardiovascular: ______________

3. HYPERTENSION

Does your patient have blood pressure consistently greater than 200 systolic or greater than 110 diastolic (treated or untreated)?

☐ No ☐ **Yes**

If yes, today the blood pressure readings are:

Systolic: ____________________ Diastolic: ____________________

4. DIABETES

Does your patient have diabetes controlled by medication?

☐ No ☐ **Yes**

(If No, go to Question 5. If Yes, please complete the following.)

Diabetes controlled by ☐ Insulin ☐ Tablet

Is your patient compliant with medication ? ☐ No ☐ **Yes**

Patient experiences early warning symptoms of hypoglycaemia ?

☐ No ☐ **Yes**

Date of last episode: ______________________

Any end organ effects: *please specify:* ___________________________

5. HEARING LOSS

Does your patient have severe hearing loss? ☐ No ☐ **Yes**

Refer to 'Assessing Fitness to Drive' publication for definition of 'severe hearing loss'

(If No, go to Question 6.)

6. MUSCULOSKELETAL DISORDER

Does your patient have a musculoskeletal disorder? ☐ No ☐ **Yes**

(If No, go to question 7. If Yes, please complete the following.)

Please tick the appropriate condition(s):

☐ Arthritis
☐ Other Musculoskeletal Disorders
☐ Limb

Is the condition likely to affect driving? ☐ No ☐ **Yes**

7. NEUROLOGICAL / NEUROMUSCULAR CONDITIONS

Does your patient have a neurological / neuromuscular condition?

☐ No ☐ **Yes**

(If No, go to question 8. If Yes, please complete the following.)

Please tick the appropriate condition(s):

☐ Brain Aneurysm
☐ Cerebral Palsy
☐ Cognitive decline
☐ Dementia
☐ Epilepsy
☐ Head Injury
☐ Intellectual Impairment
☐ Meniere's Disease
☐ Multiple Sclerosis
☐ Muscular Dystrophy
☐ Parkinson's Disease
☐ Seizures
☐ Space-occupying Lesion (incl brain tumour)
☐ Stroke
☐ Subarachnoid Haemorrhage
☐ Vertigo
☐ Other: ____

8. PSYCHIATRIC DISORDER

Does your patient have a mental health/nervous disorder?

☐ No ☐ **Yes**

(If No, go to question 9. If Yes, please complete the following.)

Please tick the appropriate condition(s):

☐ Anxiety Disorder
☐ Bipolar Affective Disorder
☐ Chronic Depression
☐ Personality Disorder
☐ Post Traumatic Stress Disorder (PTSD)
☐ Schizophrenia
☐ Tourette's Syndrome
☐ Other: ______________________

Does your patient require medication? ☐ No ☐ **Yes**

If Yes - is your patient compliant with medication? ☐ No ☐ **Yes**

Is the condition likely to affect driving? ☐ No ☐ **Yes**

9. SLEEP DISORDER

Does your patient have a sleep disorder? ☐ No ☐ **Yes**

(If No, go to question 10. If Yes, please complete the following.)

☐ Narcolepsy
☐ Sleep Apnoea
☐ Other: ___________________________

10. SUBSTANCE MISUSE

Does your patient misuse alcohol or drugs? ☐ No ☐ **Yes**

If yes, complete the following

☐ Alcohol?
☐ Illicit drugs?
☐ Prescription drugs?

Is the patient involved in appropriate treatment program(s)? ☐ No ☐ **Yes**

Any end organ effects: *(please specify)*______________________________

SECTION 4: EYESIGHT CERTIFICATE (Must be completed in all cases)

11. If the patient has one or more of the following eye or vision conditions, the Eyesight Certificate must be completed by an Optometrist or Ophthalmologist. Please tick condition/s.

☐ Diplopia ☐ Glaucoma ☐ Monocular Vision ☐ Poor Night Vision

☐ Retinitis Pigmentosa ☐ Visual Field Defect ☐ Other condition which may impair their ability to drive (please specify)

____

Additionally, if your patient's visual acuity with corrective lenses in the better eye or with both eyes together is worse than 6/12 an Optometrist or Ophthalmologist must complete the Eyesight Certificate.

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 2012? ☐ No ☐ **Yes**
(refer to vision and eye disorders in "Assessing Fitness to Drive" publication)

Are glasses or contact lenses required for driving? ☐ No ☐ **Yes**

Please provide any additional information below.

If you are not completing the other sections of this form please provide your details.

______________________________ ____ /____ /____
Medical Practitioner's name *Date*

______________________________ ______________ ______________
Medical Practitioner's signature *Provider Number* *Contact Number*

ADDITONAL NOTES: Provide comment to each ☑ **Yes** condition(s) below including reference to the specific condition (e.g. 4. Diabetes)

SECTION 5: MEDICAL PRACTITIONER'S DECLARATION

Under section 148 of the Motor Vehicles Act 1959 you have a legal obligation to inform the Registrar of Motor Vehicles if you have reasonable cause to believe that your patient is suffering from a physical or mental illness, disability or deficiency that is likely to endanger the public if your patient drives a motor vehicle.

If you consider it prudent you may recommend that your patient undertakes a practical driving assessment. This is irrespective of your patient's age or driver's licence class.

Patients who hold a licence other than a "car" licence are required to undergo a practical driving assessment at age 85 and every year thereafter.

If you consider that your patient may be unfit to drive, please immediately return the completed certificate to **Locked Bag 700, Adelaide SA 5001. Information may be immediately faxed to 8402 1977.**

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

MEDICAL PRACTITIONER'S DECLARATION

On______ /_____ /__________ I examined ____
(Date of Examination) *(Patient's name)*

This 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 Yes ☐ No ☐
If no, please provide details below:

____

____

____

____

Requires a practical driving test Yes ☐ No ☐

____

____

____

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

____

____

____

____

____

☐ Further comments on medical condition(s) affecting safe driving are attached.

I certify that I personally examined the above named patient in accordance with Assessing Fitness to Drive 2012.

____ _____ /_____ /_____
Medical Practitioner's signature *Date*

____ ____________________
Medical Practitioner's name *Provider Number*

____
Practice Address

______________ ______________ ______________
Telephone Number *Facsimile Number* *E-mail Address*