

# Confidential Medical Examination Report

## Instruction Sheet

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**The Driver/Patient Section is to be completed by the Driver/Patient.**

1. The Driver/Patient should fill in their Name, Address, Customer Identification Number, if known, and Date Of Birth.
2. The Driver/Patient should sign this section.

**The Physician/Ophthalmologist section is to be completed by a Physician (MD or DO), Physicians Assistant (PA), Advanced Practice Registered Nurse (APRN) or an Ophthalmologist/Optometrist (OD).**

1. The form is valid for 180 days from the date of the examination.
2. If the 'Require DMV retesting in one year?' question is not answered, "No" will be assumed and selected as a default answer.
3. The Physician/Ophthalmologist observation section required fields must be completed.
4. Only **one** of the fitness to operate options must be selected.
5. Any alterations, erasures or multiple selections of the fitness to operate options will result in an invalid and rejected form.
6. The form must be signed by a Physician (MD or DO), Physicians Assistant (PA), Advanced Practice Registered Nurse (APRN) or an Ophthalmologist/Optometrist (OD).

**If a DR 2401 is requested by the Department of Motor Vehicles, Drivers License Office, the examination date on the form needs to be after the issue date of the notice of cancellation and denial. The form is valid for 180 days from the date of the examination.**

## Confidential Medical Examination Report

### Driver/Patient Section

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Patient Last Name First Name Middle Initial

Street Address

City State ZIP Code

Customer Identification Number (CIN) Date of Birth

#### Driver Statement of Understanding (Driver signature not required for DMV processing):

- My physician will conduct a medical examination to determine my fitness to operate a motor vehicle safely and responsibly.
- My physician will respond to any additional questions from the Department of Motor Vehicle (DMV).
- I understand that this form will be considered in any decision regarding the issuance of my driver license, pursuant to C.R.S. 42-2-111 & 42-2-112.

Signature of Driver or Patient Date (MM/DD/YY)

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#### Driver/Patient (respond to all questions below before seeing your physician)

1. How many driving trips do you make in a typical week?.....
2. Do any of your regular trips involve driving at night?..... Yes No
3. What is the one-way distance of your furthest regular trip?..... Miles
4. Do any of your regular trips involve speeds  $\geq$  55 MPH?..... Yes No
5. Were you pulled over by a police officer in the past year?..... Yes No
6. Were you involved in a crash as a driver in the past year?..... Yes No

## Physician Section

**Instructions:** Use your best clinical judgment as you **Review and Complete All Sections**. Base severity ratings within each category on your overall assessment of impairment relative to the driving task. **Form must be completed by the Physician (MD or DO), Physician's Assistant (PA) or Advanced Practice Registered Nurse (APRN).** Pursuant to C.R.S. 42-2-112, no civil or criminal action shall be brought against a Physician, Physician Assistant or Advanced Practice Registered Nurse (APRN) licensed in Colorado for providing a written medical opinion if the Physician, Physician Assistant or Advanced Practice Registered Nurse (APRN) acts in good faith and without malice.

**Examination Date** (MM/DD/YY)

**(Form is valid for 180 days from date of exam)**

**Are you the primary care provider for this patient?**..... Yes No

If yes, how many times have you seen this patient in the past year?..

If no, are you evaluating this patient for the first time today?..... Yes No

If no, have you reviewed the patient's medical records?..... Yes No

**To your knowledge, is this patient:**

Aware of his or her medical diagnosis & status?..... Yes Somewhat No

Aware of functional impairments that may impact driving?..... Yes Somewhat No

Compliant with medications & basic requirements of self-care?..... Yes Somewhat No

**Does this patient have:**

Cardiovascular Disease..... Yes No

Cardiac Arrhythmia..... Yes No

Heart Failure..... Yes No

**AHA Functional Capacity (check level if applicable):** N/A I II III IV

**Require DMV retesting in one year?**..... Yes No

**Current Medications**

To your knowledge, is this patient subject to any consistent medicine side effects or interactions that may impair driving ability?

Yes Possibly Not Likely No

Based on my observations of this patient and information relayed to me by this individual, I, reasonably and in good faith, believe that:

Patient Name

is

**Must Choose One:**

Fit to operate a motor vehicle safely.

Fitness to drive determination pending; rehab permit required

Fit to operate a motor vehicle safely contingent upon passing a DMV Road Test.

**Not Fit** to operate a motor vehicle safely and responsibly due to significant medical-functional compromise or deficit.

**Recommended license restriction(s):**

Daylight Driving Only

Specialty Cushion

Mile Radius Only

No Highway/Freeway Driving

Foot Device

Hand Control

Automatic Transmission Only

Steering Device

Restricted MPH

Other

Patient also requires an eye exam

**Cognitive, Cerebrovascular or Neurological**

Condition is:

Stable

Progressive

N/A

Mental Status (list test and score)

Confusion or Disorientation

Memory Loss or Forgetfulness

Inattention or Distractibility

Impaired Judgment

Visual-Spatial Deficit

Slowed Processing Speed

**Cognitive Impairment:**

**Cerebrovascular Disease:**

**Neurological Condition:**

Alzheimer's Disease

Cerebral Infarction or Stroke

Brain Injury (open or closed)

Vascular Dementia

Hemorrhage or Aneurysm

Tumor or Malformation

Frontotemporal or Pick's

Transient Ischemic Attack

Parkinson's Disease

Dementia (other or unknown)

Carotid Occlusion or Hypoxia

Multiple Sclerosis

**Combined Impairment for Driving**, Select Highest Level for Section.

**Unimpaired**  
(Likely fit to Drive)

**Very Mild**  
(Likely fit to Drive)

**Mild**  
(Questionable Fitness)

**Moderate**  
(Likely Unfit to Drive)

**Severe**  
(Unfit to Drive)



**Consciousness, Metabolic or Respiratory** Condition is: Stable Progressive N/A

\*Date of last event with impaired consciousness (MM/DD/YYYY):

Disorder of Consciousness or Alertness*	Metabolic Condition	Respiratory Condition
Blackout or Syncope*	Diabetes (Type 1 or 2)	Asthma or shortness of Breath
Chronic Sleep Deprivation	Thyroid Condition (Hypo or Hyper)	COPD
Sleep Apnea or Narcolepsy	Morbid Obesity or Fluid retention	Oxygen Dependent
Epilepsy or Seizure Disorder		
Medication Effect		
Dizziness or Postural Hypotension		

**Combined Impairment for Driving**, Select Highest Level for Section.

<b>Unimpaired</b> (Likely fit to Drive)	<b>Very Mild</b> (Likely fit to Drive)	<b>Mild</b> (Questionable Fitness)	<b>Moderate</b> (Likely Unfit to Drive)	<b>Severe</b> (Unfit to Drive)
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**Musculoskeletal, Movement or Neuromuscular** Condition is: Stable Progressive N/A

Arthritis (Osteo or Rheumatoid)	Frailty or General Weakness	Motor Neuron Disease	Orthopedic or Movement
Uses Cane or Walker	Paralysis - Arm	Multiple Sclerosis	Muscular Dystrophy
Wheelchair Dependent	Paralysis - Leg	Restricted or Weakness - Arm	Parkinson's Disease
Difficulty Transferring	Prosthesis or Brace - Arm	Restricted or Weakness - Leg	Loss of Limb
Problems with Balance	Prosthesis or Brace - Leg	Restricted Neck Range of Motion	History of Falls
Other			

**Combined Impairment for Driving**, Select Highest Level for Section.

<b>Unimpaired</b> (Likely fit to Drive)	<b>Very Mild</b> (Likely fit to Drive)	<b>Mild</b> (Questionable Fitness)	<b>Moderate</b> (Likely Unfit to Drive)	<b>Severe</b> (Unfit to Drive)
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**Psychiatric, Emotional or Addiction**

Condition is:

Stable

Progressive

N/A

Depression

Bipolar Mood Disorder

Psychosis or  
SchizophreniaAlcohol Abuse or  
Addiction

Drug Abuse or Addiction

Suicidal or Homicidal

Anxiety or Post-  
Traumatic StressChronic Pain  
(causing distress)

Other

**Combined Impairment for Driving**, Select Highest Level for Section.**Unimpaired**  
(Likely fit to Drive)**Very Mild**  
(Likely fit to Drive)**Mild**  
(Questionable Fitness)**Moderate**  
(Likely Unfit to Drive)**Severe**  
(Unfit to Drive)

Physician Specialty (Required)

License Number (Required)

Phone Number (Required)

Street Address

City

State ZIP Code

Patient Last Name

First Name

Middle Initial

Physician Name (Printed)

Physician Signature (Required)

Date (MM/DD/YY)