Medical Assessment for Public Passenger Vehicle Drivers

Transport for NSW

Given names

Surname

Date of Birth
day / month / year

Gender
Male ☐
Female ☐

Driver licence number

Residential address *(PO box not accepted)*

Postcode

Contact phone number

Email address

INFORMATION FOR HEALTH PROFESSIONALS

This customer is applying for a public passenger vehicle driver authority and requires a Fitness to Drive medical assessment to complete their application.

To complete this assessment refer to the medical standards applicable (commercial) and any declared medical conditions. Prior to commencing the assessment, refer to the relevant medical standards as detailed in 'Assessing Fitness to Drive' available on the Austroads website.

NSW DIGITAL FITNESS TO DRIVE MEDICAL ASSESSMENTS – Health professionals can now complete this medical assessment online using BEST PRACTICE, GENIE OR MEDICAL DIRECTOR. Submitting medical assessments to Transport for NSW using the digital forms will be immediate, resulting in faster case reviews and completions. For patients, the digital forms will be immediate, resulting in faster case reviews and completions. Health professionals can obtain more information about Healthlink at au.healthlink.net/kb

Completing the assessment: If you wish to complete the form digitally, you simply need to submit the form through the online system. If you wish to complete the form manually, return the completed form to the patient to submit direct to a Service NSW Centre. Location details are available at **service.nsw.gov.au** or phone 13 22 13.

PRIVACY STATEMENT: We are collecting your personal information in connection with your fitness to drive assessment. We may retain, use and disclose your personal information in connection with verifying your identity and your assessment. We cannot accept your assessment unless you provide this information. Your personal information will be held and managed by Transport for NSW in accordance with the Privacy and Personal Information Protection Act 1998. To access or amend your personal information please use the access and amendment application forms available at **www.transport.nsw.gov.au/about-us/transport-privacy**

Please return this form to:
Licence Review Unit
Locked Bag 14
Grafton NSW 2460
Email: da.medicals@transport.nsw.gov.au

INFORMATION FOR THE APPLICANT

The information provided by your medical practitioner is important in deciding whether you meet the commercial medical standards for the purpose of driving public passenger vehicles and for the purpose of whether to grant, renew, suspend or cancel your driver licence or impose a condition on it.

Personal Information Collection Notice

Transport for NSW is committed to protecting your privacy and ensuring your personal and health information is managed according to law. Find out why we collect your personal information, including how we use and manage it, by reading our privacy statement at **www.transport.nsw.gov.au/privacy-statement** or phone 13 22 13 to request a copy. If your application relates to a Public Passenger Vehicle Driver Authority we may also disclose your personal information or health information, where relevant, to accredited operators, networks, booking or rideshare service providers under the Passenger Transport Act 2014 in connection with the administration of any such legislation.

Roles and Responsibilities of the driver

Legislation requires a driver to advise Transport for NSW of any long-term injury or illness that may affect his or her safe driving ability. These laws may impose penalties for failure to report. As well as these legal obligations, a driver may be liable at common law if he or she continues to drive knowing that he or she has a condition that is likely to adversely affect safe driving.

NSW Fitness to Drive Medical Assessment
Commercial Standards

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. Does the patient have a vision or eye disorder? ☐ **Yes** ☐ **No**

If Yes, *please tick the condition(s). Refer to part B:10 of Assessing Fitness to Drive, pg 128-130.*

☐ Cataracts ☐ Diplopia/Double vision ☐ Glaucoma
☐ Monocular vision ☐ Poor night vision ☐ Macular degeneration
☐ Other, specify: _____
☐ *Tick if the condition(s) indicated above is corrected by wearing glasses or contacts. Refer to part B:10 Figure 15, pg 125.*

2. 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. Does the patient have a restricted visual field or a visual field defect? *Refer to part B:10-10.2.2, pg 125.* ☐ **Yes** ☐ **No**

List visual fields in degrees: _____

☐ *Tick if the binocular visual fields do not meet the standards*

Optometrist or ophthalmologist details*. Complete only if relevant***:**

Name: _____ **Date:** _____

Signature: _____ **Tel No:** _____

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

If Yes, *please tick the condition(s). Refer to part B:2, pg 45-57.*

☐ Acute Myocardial Infarct ☐ Aneurysms (abdominal & thoracic)* ☐ Angina ☐ Angioplasty
☐ Cardiac Arrest ☐ Cardiac Defibrillator (ICD)** ☐ CABG ☐ Congenital Disorders
☐ Dilated Cardiomyopathy ☐ HCM Cardiomyopathy ☐ Heart Transplant ☐ Heart Failure
☐ Pacemaker ☐ Other *(Refer to part B:2, pg 53-57):* _____

**Specify size of Aneurysm:* _____

☐ *Tick if repaired and does not impact driving ability*

***All patients with an ICD implant require periodic specialists referral and cannot hold a commercial licence. Refer to part B:2, pg 50.*

5. Does the patient have diabetes? ☐ **Yes** ☐ **No**

If Yes, *indicate the medication. Refer to part B:3, pg 63-65.*

☐ Insulin ☐ Tablets/other non insulin agents
☐ *Tick if patient is not compliant with medication*

Specify any end organ effects: _____

6. Does the patient have epilepsy? *Refer to part B:6, pg 89-94.* ☐ **Yes** ☐ **No**

***If Yes,** specify* _____ *Date of last two seizures: (a)* _____ *(b)* _____

☐ *Tick if the diagnosis is confirmed by a specialist* *Date medication ceased, if applicable:* _____

7. Does the patient have Dementia or other cognitive impairment? *Refer to part B:6, pg 80.* ☐ **Yes** ☐ **No**

Specify: _____

☐ *Tick if specialist referral is required. Refer to part B:6-6.1.2, pg 77.*

8. Does the patient have a neuromuscular condition? *Refer to part B:6, pg 103.* ☐ **Yes** ☐ **No**

Specify: _____

_____

Tick if specialist referral is required

Tick if driving assessment is required ☐

9. Does the patient have vestibular, neurological or other neurodevelopmental disorders? ☐ **Yes** ☐ **No**

If Yes, *tick the condition(s). Refer to part B:6, pg 100-105.*

☐ 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
☐ Stroke: Date of most recent episode*: _____ ☐ Syncope: Date of most recent episode: _____
☐ Other specify*:* _____

**If within the last 12 months specialist referral is required.*

10. Does the patient have sleep apnoea or narcolepsy? ☐ **Yes** ☐ **No**

If Yes, *tick the condition(s). Refer to part B:8, pg 115.*

☐ Narcolepsy ☐ Tick if not well controlled. *All patients with Narcolepsy must see a specialist.*

☐ Sleep Apnoea ☐ Tick if not well controlled. *Refer all commercial drivers with sleep apnoea to a specialist.*

11. Does the patient have mental health issues? ☐ **Yes** ☐ **No**

If Yes, *tick the condition(s). Refer to part B:7, pg 110. Refer to part B:7-7.2, pg 108-109 for general assessment guidelines.*

☐ Anxiety disorder ☐ ADHD ☐ Bipolar affective disorder ☐ Chronic depression

☐ Personality disorder ☐ PTSD ☐ Schizophrenia ☐ Tourettes

☐ Other, specify: _____

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

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

☐ *Tick if the condition is of such severity that it requires a psychiatric review*

12. Does the patient have a musculoskeletal disorder? ☐ **Yes** ☐ **No**

If Yes, *tick the condition(s). Refer to part B:5, pg 74.*

☐ Chronic pain ☐ Deformities ☐ Loss of digits ☐ Loss of limbs ☐ Severe arthritis ☐ Other

☐ Specify condition: _____

☐ *Tick if the patient requires vehicle modifications*

☐ *Tick if the Transport for NSW practical driving test is required*

☐ *Tick if an occupational therapist driving assessment is required*

13. Is the patient dependant on drugs or alcohol (eg based on ICD-10 criteria)? ☐ **Yes** ☐ **No**

If Yes, *refer to part B:9, pg 120-121.*

☐ *Tick if the patients' alcohol use disorder is likely to affect safe driving.* Specify: _____

☐ *Tick if the patient's illicit drug use is likely to affect safe driving.* Specify: _____

☐ *Tick if the patient is in a treatment program*

☐ *Tick if patient requires specialist referral*

Specify any end organ damage that could affect driving: _____

14. Is the patient taking multiple medications that may affect driving?* *Refer to part A:2-2.8, pg 11-12.* ☐ **Yes** ☐ **No**

If Yes, specify effects on driving _____ **Please refer the patient for a Home Medicine Review, if appropriate*

15. Does the patient have severe hearing loss? *For commercial drivers only. Refer to part B:4, pg 68-69.* ☐ **Yes** ☐ **No**

APPLICANT'S DECLARATION AND CONSENT

This section must be completed

I declare I have provided true and complete details to my medical practitioner. I consent to my medical practitioner providing my health 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) 2016 or, if applying for a Public Passenger Vehicle Driver Authority, under the *Passenger Transport Act 2014*.

Signature: _____ **Date:** _____

Doctor or Medical Specialist's Certification

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 patients medical history before undertaking this assessment? *Refer to part A:3-3.3.4, pg 18. If you ticked no, request the patient's medical file from their regular practitioner and/or conduct a more thorough examination than usual to ensure they meet the Assessing Fitness To Drive medical standards* ☐ **Yes** ☐ **No**

Any additional comments on conditions likely to affect driving? *If Yes,* *attach supplementary documents* ☐ **Yes** ☐ **No**

☐ This assessment has been undertaken in accordance with the commercial medical standards as set out in the 'Assessing Fitness to Drive' (Commercial and Private Vehicle Drivers) 2016

In my opinion, the patient of this assessment: *Tick one option. Refer to part A:4-4.4. pg 22.*

☐ **Option 1:** Meets the medical criteria for an unconditional licence

☐ **Option 2:** Meets the medical criteria for an unconditional licence and requires annual medical assessment (drivers 75+)

☐ **Option 3:** Meets the medical criteria subject to further assessment (practical driving test or specialist medical review)

☐ **Option 4:** Meets the medical criteria for a conditional licence, subject to periodic medical review (indicate restrictions below if appropriate)

☐ **Option 5:** Does not meet the medical criteria for an unconditional or conditional driver licence

If Option 3 ticked: Which assessment is recommended? *Tick requirements.*

☐ Transport for NSW practical driving test
☐ Occupational therapist driving assessment
☐ Review by a specialist. *Specify:* _____

If Option 4 ticked: What are the recommended licence conditions? *Tick all that is relevant. Refer to part A:4, pg 23-24.*

☐ Downgrade to a lower class of licence. *Specify*: _____
☐ Daylight hours only
☐ Modified vehicle. *Specify:* _____
☐ Radius restriction. Specify distance:
☐ *2km* ☐ *5km* ☐ *10km* ☐ *15km* ☐ *20km* ☐ *30km* ☐ *40km* ☐ *50km* ☐ *75km* ☐ *100km*
☐ Extension of the Alcohol Interlock Program (for a patient currently on the Program)

Date: _____

Doctor's name: _____ **Signature:** _____

Field of Practice: _____

Address: _____

_____

Tel No: _____ **Fax No:** _____ **Email *(optional)*:** _____

Office Use Only

CSR Name and Signature, Staff Number, SNSW Service centre stamp and date

Refer to Licence Review Unit