



Department of Transport
 GPO Box 530, DARWIN NT 0801
 Phone: 1300 654 628
 Fax: (08) 8999 3103
 Email: mvr.medical@nt.gov.au
 Website: www.mvr.nt.gov.au

L2

MEDICAL ASSESSMENT OF FITNESS TO DRIVE

Effective Date: 31 March 2014

THE FORM SHOULD BE COMPLETED BY THE EXAMINING DOCTOR AND PROVIDED TO THE DRIVER

Driver information:	Surname:	Given name(s):		
Address:				
Phone:	Date of birth:	Driver Licence no.	Male or Female:	

New Licence Application Current Licence

Type	Motor Car	Light Rigid	Medium Rigid	Heavy Rigid	Heavy Combination	Multi-Combination	Motorcycle	Hire or Reward	Driving Instructor
Class	C	LR	MR	HR	HC	MC	R	"H"	"D"

Assessment outcome:

I was familiar with the driver's medical history before conducting this assessment Yes No
 I have sighted the driver's licence Yes No
 Patient examined according to Private vehicle standards Commercial vehicle standards

I have examined the driver in accordance with Assessing Fitness to Drive 2012 standards and in my opinion the driver (tick ONE box from 1 to 4 and indicate recommended management):

- 1. Unconditionally meets the medical criteria for fitness to drive**
 Meets all relevant medical criteria. No restrictions or conditions. See recommended date of next review below.
- 2. Conditionally meets the medical criteria for fitness to drive**
 Has a medical condition that may impact on fitness to drive, but it is well controlled and meets the **conditional** criteria in *Assessing Fitness to Drive 2012*. May require person to be more frequently reviewed than prescribed under normal periodic review. See recommended date of next review below.
 Person is required to wear the following aids/devices:
 Corrective lenses Hearing aid Other aids/devices (specify):
- 3. Temporarily does not meet the medical criteria for fitness to drive**
 Does not meet relevant medical criteria (Unconditional or Conditional) and should not undertake normal driving duties. May perform alternative tasks. May return to driving following: an improvement in condition, response to treatment or confirmed diagnosis of undifferentiated illness.
- 4. Permanently does not meet the medical criteria for fitness to drive**
 Does not meet relevant medical criteria and cannot perform normal driving duties in the foreseeable future.

Recommended management:

- Local doctor referral Practical driver test
 Specialist referral More frequent periodic review (see recommended review date below)
 Laboratory tests Other, please describe (Please attach additional information to the form if required or complete overleaf)
 Drug test

Recommended date of next review (from date of assessment):
 1 year 2 years 3 years 4 years 5 years Other (specify)

Eyesight Test Result:
 Left Eye: 6/_____ Right Eye: 6/_____ Both Eyes: 6/_____

Health professional's details

Name:	Phone:	Facsimile:
-------	--------	------------

Practice address:

Signature:	Date of assessment:
------------	---------------------

Further comments from the examining Health Professional:

Driver Licence holders/applicants declaration:

Statutory Declaration

I,
(Full Name)

of.....
(Address)

do solemnly and sincerely declare that the information supplied to the Health Professional for the purpose of conducting an assessment of my medical fitness to drive was true and correct and I make this solemn declaration by virtue of the *Oaths, Affidavits and Declarations Act*.

I hereby consent to the Motor Vehicle Registry obtaining relevant traffic related history from any source, including Police and other road authorities, for the purpose of determining my eligibility to hold a driver/rider licence, including the sharing of my traffic related history with Health Professional's conducting assessments of my medical fitness to drive

Declared at on the day of.....20.....

Signature of person making the declaration

Signature of person before whom the declaration is made

Name and contact address or phone number of person before whom the declaration is made, legibly written, typed or stamped

The Registrar of Motor Vehicles has a responsibility to ensure that all drivers have the appropriate skills, abilities, and are medically fit to hold a driver licence. To meet this responsibility, legislation gives the Registrar of Motor Vehicles the authority to ask any driver licence holder or applicant to provide medical evidence of their suitability to drive and/or undergo a driver assessment.

To the Driver/Applicant

- Make an appointment with your medical practitioner.
- As the examination may take longer than a routine consultation, please advise the receptionist when making the appointment that you are attending for this purpose.
- If you wear spectacles, hearing aids etc, please bring them to the examination.
- Take this form to the appointment for your doctor to complete.
- You are required by law to advise the Registrar of Motor Vehicles of any conditions that may affect your ability to drive. You should make the doctor aware of any medical conditions you may have so that your doctor can advise the Registrar of Motor Vehicles, on your behalf, using this form.
- If the medical report has been requested for a particular reason, you should let your practitioner know this reason.
- You should let your doctor know if you hold or are applying for a heavy vehicle or commercial licence, as the medical requirements for drivers of such vehicles are stricter.
- On completion of the examination the doctor will provide you with this form to return to the Motor Vehicle Registry.
- Payment for the medical examination is the responsibility of the licence holder/applicant.
- **Withdrawal of Licence** – If the Registrar of Motor Vehicles takes away your licence on the basis of a medical report, you may be re-licensed when you provide medical evidence indicating that you now meet the national medical standards. You should be aware that you have the right to seek a review of any decision affecting your licence.
- Any queries regarding licensing may be directed to the Motor Vehicle Registry on 1300 654 628.

To the Health Professional

- The examination must be conducted in accordance with the national medical standards described in *Assessing Fitness to Drive 2012*.
- This publication is available via the web: www.austroads.com.au/aftd.
- On completion of the examination please fill in and sign the certificate.
- You should be aware of the patient's history prior to conducting the examination.
- Distribute the completed certificate as follows:
 1. Hand the original Medical Assessment of Fitness to Drive certificate (together with additional information relevant to the patient's fitness to drive) to the patient to present to the Motor Vehicle Registry.
 2. Retain a copy of the entire L2 package together with your detailed examination notes for the patient's medical record.
- If you have doubts about your patient's suitability to drive, you may suggest a driver assessment or referral to a suitable specialist. Please indicate this in the space provided. If you have any doubts about the information required, or wish to discuss the case personally, please contact the Manager Licensing Compliance or Medical Licence Compliance Officer on 1300 654 628.
- **Indemnity** – Northern Territory legislation mandates reporting of unfit drivers by health professionals, thereby affording indemnity to practitioners who conduct an examination and provide Driver Licensing Authorities with an opinion based on that examination.
- **Criminal Liability & Insurance** – Health professionals may be liable under civil law in cases where a court forms the opinion that they have not taken reasonable steps to ensure that impaired drivers drive only in circumstances that do not place them and other members of the community at increased risk. Professional indemnity insurers are aware of the potential liability of health professionals and may reasonably expect health professionals to comply with the national medical standards.

Information not relevant to the patient's fitness to drive should not be forwarded to the Motor Vehicle Registry.

Occupational Therapy Driver Assessment

- Trained occupational therapists may conduct a driver assessment where there is a medical concern about the patient's ability to drive safely.
- The aim of the occupational therapy assessment is to assist people with impairments to resume or continue driving. There are two components of the assessment.
- The first part of the assessment aims to evaluate the person's difficulties. This involves an interview, vision screen, cognitive function test, assessment of physical strength, motor skills, reaction time, road law and road craft. The need for specialist equipment or vehicle modifications is considered at this time.
- The on-road assessment takes a standard approach but can be designed to meet individual needs. It is conducted in a dual controlled vehicle, accompanied by a driving instructor and where necessary set up with special requirements or modifications to meet the needs of the client. The assessment is structured to assess the impact of injury, illness or the ageing process on driving skills such as judgement, decision-making skills, observation and vehicle handling.
- Provided the overall drive is safe, the 'bad habits' that an experienced driver might display may not result in failure.

Conditions and Restrictions

- If appropriate, the practitioner may recommend conditions, which may enhance driver competency or safety and allow their patient to continue to drive (eg. corrective lenses, no night driving, additional mirrors).
- If the practitioner recommends a licence with conditions, details of the recommended restrictions and reasons must be provided, otherwise a licence will not be considered.
- If the practitioner believes that vehicle modifications are necessary (e.g. hand controls, left foot accelerator), or a prosthesis is necessary to drive safely, or that a local area driving restriction is appropriate, the patient may need to demonstrate the ability to drive safely with these restrictions. In these cases, a driver assessment is necessary.

Motor Vehicle Registry Driver Assessment

- Where there is a concern about a person's ability to drive safely, a driving test may be necessary.
- Assessments of this nature are generally conducted in consultation with an Occupational Therapist trained in this area.

Privacy Statement

The Registrar of Motor Vehicles is required to collect information for registrations, licences and permits under section 92 of the *Motor Vehicles Act*. The Registrar adheres to the Department's Privacy Statement and the Information Act. Further information on privacy can be found at www.transport.nt.gov.au/mvr/about-us



Department of Transport
GPO Box 530, DARWIN NT 0801
Phone: 1300 654 628
Fax: (08) 8999 3103
Email: mvr@nt.gov.au
Website: www.mvr.nt.gov.au

DRIVER HEALTH QUESTIONNAIRE

Effective Date: 31 March 2014

Driver information:

Surname:	Given name(s):
Address:	
Date of birth:	Phone:
Driver licence number:	State of issue:

Instructions for completion:

Driver to complete questionnaire and doctor to retain on record. Do not return this form to the Motor Vehicle Registry.

Please answer the questions by ticking the appropriate box. If you are not sure what a question means, leave the answer blank and the doctor will help you. The doctor may ask you additional questions during the examination. On completion of the questionnaire you will be asked to sign a declaration to confirm the accuracy of your responses.

Please bring with you to the assessment:

- A list of current medications
- Glasses/contact lenses and hearing aids if you use them
- Disease management plans (e.g. sleep disorder management plan, diabetes management plan)

Disclosure of health information:

Please read carefully and sign to indicate you understand how health information is reported, stored and accessed.

The details of your health assessment will remain confidential and will only be reported in terms of whether you meet the medical criteria for driving a private or commercial vehicle. The examining health professional retains all detailed medical papers including your questionnaire responses and the completed record of clinical findings. The examining health professional will provide you with the 'Medical Assessment of Fitness to Drive' report, Form L2. Other than the above, your personal information will not be disclosed to any other person or organisation without your written permission, except when required by law.

You have the right to access your health records including those held by the examining health professional and the reports held by the requesting organisation.

Driver's declaration

I have read and understood the above statement concerning the health information provided in this document.

Signature of licence holder/applicant

Date

Consent to contact treating health professionals

I consent to the examining doctor contacting any health professional to clarify aspects of my medical management.

Signature of licence holder/applicant

Date

Questions:

1.	Are you currently attending a health professional for any illness or injury?	<input type="checkbox"/> No <input type="checkbox"/> Yes
2.	Are you taking any regular medication?	<input type="checkbox"/> No <input type="checkbox"/> Yes
3.	Have you ever had a serious injury, illness, operation or accident or been in hospital for any reason?	<input type="checkbox"/> No <input type="checkbox"/> Yes

If YES to Question 1, 2 or 3 please provide brief details:

Doctor's comments:

3. Do you suffer from or have you ever suffered from any of the following:

3.1	High blood pressure	<input type="checkbox"/> No <input type="checkbox"/> Yes	3.11	Stroke	<input type="checkbox"/> No <input type="checkbox"/> Yes
3.2	Heart disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	3.12	Dizziness, vertigo, problems with balance	<input type="checkbox"/> No <input type="checkbox"/> Yes
3.3	Chest pain, angina	<input type="checkbox"/> No <input type="checkbox"/> Yes	3.13	Memory loss or difficulty with attention or concentration	<input type="checkbox"/> No <input type="checkbox"/> Yes
3.4	Any condition requiring heart surgery	<input type="checkbox"/> No <input type="checkbox"/> Yes	3.14	Other neurological disorder	<input type="checkbox"/> No <input type="checkbox"/> Yes
3.5	Palpitations / irregular heartbeat	<input type="checkbox"/> No <input type="checkbox"/> Yes	3.15	Neck, back or limb disorders	<input type="checkbox"/> No <input type="checkbox"/> Yes
3.6	Abnormal shortness of breath	<input type="checkbox"/> No <input type="checkbox"/> Yes	3.16	Double vision, difficulty seeing	<input type="checkbox"/> No <input type="checkbox"/> Yes
3.7	Diabetes	<input type="checkbox"/> No <input type="checkbox"/> Yes	3.17	Colour blindness	<input type="checkbox"/> No <input type="checkbox"/> Yes
3.8	Head injury, spinal injury	<input type="checkbox"/> No <input type="checkbox"/> Yes	3.18	Hearing loss or deafness or had an ear operation or use a hearing aid	<input type="checkbox"/> No <input type="checkbox"/> Yes
3.9	Seizures, fits, convulsions, epilepsy	<input type="checkbox"/> No <input type="checkbox"/> Yes	3.19	A psychiatric illness or nervous disorder	<input type="checkbox"/> No <input type="checkbox"/> Yes
3.10	Blackouts or fainting	<input type="checkbox"/> No <input type="checkbox"/> Yes			

Doctor's comments:

4. Sleep

4.1	Have you ever been tested for a sleep disorder or been told by a doctor that you have a sleep disorder, sleep apnoea or narcolepsy?	<input type="checkbox"/> No <input type="checkbox"/> Yes			
4.2	Has anyone told you that your breathing stops or is disrupted by episodes of choking during your sleep?	<input type="checkbox"/> No <input type="checkbox"/> Yes			
4.3	How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? <i>This refers to your usual way of life in recent times. If you haven't done some of these things recently try to work out how they would have affected you.</i>				
		would never doze off (0)	slight chance of dozing (1)	moderate chance of dozing (2)	high chance of dozing (3)
a	Sitting and reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b	Watching TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

c	Sitting inactive in a public place (e.g. a theatre or a meeting)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d	As a passenger in a car for an hour without a break	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e	Lying down to rest in the afternoon when circumstances permit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f	Sitting and talking to someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g	Sitting quietly after a lunch without alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h	In a car, while stopped for a few minutes in the traffic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Doctor's comments:

6. Alcohol and Other Drugs

6.1 Have you ever sought assistance for alcohol or substance use issues? No Yes

6.2	Please circle the answer that best describes your situation.	(0)	(1)	(2)	(3)	(4)
a	How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times per month	2 to 3 times per week	4 or more times per week
b	How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 to 5	5 to 6	7 to 9	10 or more
c	How often do you have six or more drinks on one occasion?	Never	Monthly or less	2 to 4 times per month	2 to 3 times per week	4 or more times per week
d	How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Monthly or less	2 to 4 times per month	2 to 3 times per week	4 or more times per week
e	How often during the last year have you failed to do what was normally expected from you because of drinking?	Never	Monthly or less	2 to 4 times per month	2 to 3 times per week	4 or more times per week
f	How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Monthly or less	2 to 4 times per month	2 to 3 times per week	4 or more times per week
g	How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Monthly or less	2 to 4 times per month	2 to 3 times per week	4 or more times per week
h	How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Monthly or less	2 to 4 times per month	2 to 3 times per week	4 or more times per week
i	Have you or someone else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year
j	Has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year
6.3	Do you currently use illicit drugs?			<input type="checkbox"/> No	<input type="checkbox"/> Yes	
	Do you use any drugs or medications not prescribed for you by your doctor?			<input type="checkbox"/> No	<input type="checkbox"/> Yes	

Doctor's comments

7. Driving Offence and Crash Involvement History

7.1 Have you been the driver of a vehicle involved in crash since your last fitness to drive examination? No Yes

If YES briefly describe the incident:

7.2 Do you have any recorded driving offences? No Yes

If YES briefly the offence and when they were recorded

7.3 Has your driving ever been impaired as a result of a medical condition/episode or as a result of the use of prescribed medication? No Yes

If YES briefly describe the incident

Doctor's comments

Statutory declaration – accuracy and completeness of information provided

I,
(Full Name)

of.....
(Address)

do solemnly and sincerely declare that the information supplied in this Driver Health Questionnaire for the purpose of conducting an assessment of my medical fitness to drive is true and correct and I make this solemn declaration by virtue of the *Oaths, Affidavits and Declarations Act*.

Declared at on the day of.....20.....

Signature of person making the declaration

Signature of person before whom the declaration is made

Name and contact address or phone number of person
before whom the declaration is made, legibly written,
typed or stamped



Department of Transport
 GPO Box 530, DARWIN NT 0801
 Phone: 1300 654 628
 Fax: (08) 8999 3103
 Email: mvr@nt.gov.au
 Website: www.mvr.nt.gov.au

CLINICAL ASSESSMENT RECORD

**THIS FORM TO BE RETAINED BY THE EXAMINING DOCTOR – DO NOT RETURN TO THE MOTOR VEHICLE REGISTRY.
 Medical information relevant to driver licensing should be included on the Medical Assessment of Fitness to Drive form (L2).**

Driver information:

Surname:	Given name(s):
Address:	
Date of birth:	Phone:
Driver licence number:	State of issue:

CLINICAL ASSESSMENT:

1. Vision

1.1 Visual acuity (refer AFTD, page 119)

Are glasses or contact lenses worn? Yes No

	R	L	Both
Without Correction	6 /	6 /	6 /
With Correction	6 /	6 /	6 /

Meets criteria Without correction With correction
 Does not meet criteria

1.2 Visual Fields Normal Abnormal (refer AFTD, page 120)

Comments:

2. Hearing (refer AFTD, page 64)

Are hearing aids worn? Yes No

Hearing level at frequencies (db)

	0.5kHz	1.0kHz	1.5kHz	2.0kHz	3.0kHz	4.0kHz	6.0kHz	8.0kHz	Average of 0.5, 1, 2, 3 kHz
Right ear									
Left ear									

Meets criteria Without hearing aid With hearing aid
 Does not meet criteria

Comments:

6. Psychological health (Refer AFTD p 100-104)

Relevant findings from questionnaire:

Mental state examination:

- | | | |
|--------------------------------------|---------------------------------|-----------------------------------|
| Appearance | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| Attitude..... | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| Behaviour..... | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| Mood and affect..... | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| Thought form stream and content..... | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| Perception..... | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| Cognition..... | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| Insight..... | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| Judgement..... | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |

Comments:

7. Sleep disorders (Refer AFTD p 105-109)

Existing sleep disorder? No Yes

ESS Score (Screen):

(Q 5 of Driver Health Questionnaire)

(Score > 16 is consistent with moderate to severe excessive daytime sleepiness)

Clinical signs of sleep disorder Absent Present

Comments:

8. Substance misuse (Refer AFTD p 110-115)

Note: Drug screening not routinely required.

Existing substance use disorder? No Yes

Audit Score (Screen):

(Q6 of Driver Health Questionnaire)

(Score > 8 indicates strong likelihood of hazardous or harmful alcohol consumption)

Clinical signs of substance misuse Absent Present

Comments:

9. Medication

Specify:

SUMMARY

Summarise significant findings

Are any further investigations or referrals required? Yes (describe) No

What is the recommendation for this driver in terms of fitness to drive?

- Unconditionally** meets the medical criteria – meets all relevant medical criteria (no restrictions)
- Conditionally** meets the medical criteria for fitness to drive – has a medical condition that may impact on fitness to drive but it is well controlled and meets the conditional criteria in *Assessing Fitness to Drive 2012*. Indicate also if:

- Driver requires aids to drive:

Vision aids Hearing aids Other devices or vehicle modifications (specify)

- Driver requires more frequent review than prescribed under normal periodic review:

Specify recommended review:

- Temporarily** does not meet the medical criteria (unconditional or conditional) – pending further investigation and treatment (record details).

- Permanently** does not meet the medical criteria (record details)

Contact(s) with other treating health professional(s)

Note: Contact is to be made with patient's consent as per questionnaire

Contact with requesting organisation (if relevant and clinically warranted)

- If the driver is classified *Temporarily or Permanently does not meet the medical criteria*, send Fitness to Drive Report immediately to requesting organisation, if relevant.

Details of contact made

Name of doctor

Signature of doctor

Date