DMV

DEPARTMENT OF TRANSPORTATION
DRIVER AND MOTOR VEHICLE SERVICES
1905 LANA AVE NE, SALEM OREGON 97314

MANDATORY IMPAIRMENT REFERRAL

(OAR CHAPTER 735 DIVISION 74)

FAX *or* Mail Instructions on Reverse of Form

THE MEDICAL INFORMATION IN THIS REPORT IS CONFIDENTIAL AND WILL BE USED BY THE DRIVER AND MOTOR VEHICLE SERVICES (DMV) ONLY TO DETERMINE THE QUALIFICATIONS OF THE PERSON TO OPERATE MOTOR VEHICLES.

LAST NAME **(PLEASE PRINT)**	FIRST NAME	MIDDLE NAME	SEX	ODL / CUSTOMER NUMBER	DATE OF BIRTH

RESIDENCE ADDRESS	CITY	STATE	ZIP CODE	COUNTY

MAILING ADDRESS (IF DIFFERENT THAN RESIDENCE)	CITY	STATE	ZIP CODE

The underlying medical condition or diagnosis is: _____ .

IMPAIRMENT(S) IS: ☐ ACUTE ☐ TRANSIENT ☐ CHRONIC ☐ PROGRESSIVE **DATE OF LAST EXAM:** _____

The patient named above is over 14 years of age and has the impairment(s) checked or described below. The impairment(s) is documented as severe and uncontrollable and not correctable by medication, therapy and/or surgery, driving device and/or techniques. Submission of this form may result in an immediate suspension of the patient's driving privileges.

Checking one or more of the boxes below indicates that the above referenced patient has one or more functional and/or cognitive impairment listed on the reverse side unless otherwise described below.

FUNCTIONAL IMPAIRMENTS: (Check all that apply.)

☐ VISUAL ACUITY and/or FIELD OF VISION
Patient is unable to meet the state vision standards listed below, even with correction:
- Acuity must be no worse than 20/70 in the best eye
- Horizontal field of vision of 110 degrees or greater (includes temporal and nasal vision of persons with usable vision in only one eye)

☐ STRENGTH
☐ PERIPHERAL SENSATION
☐ FLEXIBILITY
☐ MOTOR PLANNING & COORDINATION
☐ OTHER (describe): _____

COGNITIVE IMPAIRMENTS: (Check all that apply.)

☐ ATTENTION
☐ JUDGMENT & PROBLEM SOLVING
☐ REACTION TIME
☐ PLANNING & SEQUENCING
☐ IMPULSIVITY
☐ VISUOSPATIAL
☐ MEMORY
☐ OTHER:_____
☐ LOSS OF CONSCIOUSNESS OR CONTROL
– Date of Last Episode _____
– Medication to prevent recurrence _____

Describe how the patient is affected by the impairment(s) checked above. Please provide any information relevant to the patient's ability to safely operate a motor vehicle. Relevant information includes but is not limited to: chart notes; pertinent test results; prescription or OTC medications that may interfere with safe driving behaviors; problem drug, alcohol, or inhalant use; or other factors that may contribute to the impairment.

_____

_____

_____

_____

_____

_____

_____

_____

_____

Are you the patient's primary care provider (PCP)? ☐ **YES** ☐ **NO***

***** If "NO," does the patient have a PCP? ☐ **YES** ☐ **NO**

If DMV tests are successfully completed, should patient be required to obtain updated medical information and submit to DMV for recertification in the future? ☐ **YES** ☐ **NO**

HEALTH CARE PROVIDER'S NAME (PLEASE PRINT)	SPECIALTY	LICENSE or CERTIFICATE #

MAILING ADDRESS	FAX #	TELEPHONE #

CITY	STATE	ZIP CODE	COUNTY

SIGNATURE OF HEALTH CARE PROVIDER	DATE SIGNED
X	

INSTRUCTIONS TO HEALTH CARE PROVIDER

1. Please complete the first page with your findings and recommendations. Attach any additional information, including test results and chart notes, that will assist the State Health Officer in determining a patient's ability to safely operate a motor vehicle.

2. **FAX** *or mail* medical information and completed forms on the patient to:

DMV - DRIVER SAFETY UNIT	Phone:	(503) 945-5083
1905 LANA AVE NE	TTY:	(503) 945-5001
SALEM, OR 97314-4120	**FAX:**	**(503) 945-5329**

Submission of this Mandatory Impairment Referral form is in compliance with HIPAA regulations for the release of medical information.

IMPAIRMENT DEFINITIONS

The definitions listed below are to be used by physicians and health care providers as an aid to correctly identify the impairment listed on the front of this form. The definitions apply to those impairments that are documented as severe and uncontrollable, **and** not correctable by medication, therapy and/or surgery, **and** not correctable by driving device and/or technique.

PERIPHERAL SENSATION OF EXTREMITIES (Including but not limited to):
- Tingling and numbness and loss of position sense in extremities affecting the ability to feel, grasp, manipulate or release objects or use foot controls effectively.

STRENGTH (Including but not limited to):
- The inability to consistently maintain a firm grip on objects.
- The inability to apply consistent pressure to objects with legs and feet.
- Weakness or paralysis of muscles affecting the ability to maintain sitting balance.
- Weakness or paralysis in extremities affecting the ability to feel, grasp, manipulate or release objects or use foot controls effectively.

FLEXIBILITY (Including but not limited to):
- Rigidity and/or limited range of mobility in neck, torso, arms, legs or joints.

MOTOR PLANNING AND COORDINATION (Including but not limited to):
- Difficulty and slowness in initiating movement.
- Vertigo, dizziness, loss of balance or other motor planning conditions.
- Involuntary muscle movements.
- Loss of muscle control.

ATTENTION (Including but not limited to):
- Decreased awareness.
- Reduction in ability to efficiently switch attention between multiple objects.
- Reduced processing speed.

JUDGMENT AND PROBLEM SOLVING (Including but not limited to):
- Reduced processing speed.
- An inability to understand a cause and effect relationship.
- A deficit in decision-making ability.

REACTION TIME (Including but not limited to):
- A delayed reaction time.

PLANNING AND SEQUENCING (Including but not limited to):
- A deficit in the ability to anticipate and/or react to changes in the environment.
- Problems with sequencing activities.

IMPULSIVITY (including but not limited to):
- Lack of emotional control.
- Lack of decision–making skills.

VISUOSPATIAL (Including but not limited to):
- Problems determining spatial relationships.

MEMORY (Including but not limited to):
- Problems with confusion and/or memory loss.
- A decreased working memory capacity.

LOSS OF CONSCIOUSNESS OR CONTROL

For Official Use Only – DMV

Ref#: _____ Action: _____

Date: _____ MV#: _____

CERTIFICATE OF MEDICAL ELIGIBILITY FOR TESTING AND DETERMINATION (OFFICIAL USE ONLY - STATE HEALTH OFFICER)

BASED UPON THE ABOVE MEDICAL INFORMATION AND DMV'S MEDICAL CASE FILE, THE UNDERSIGNED REPRESENTATIVE OF THE STATE HEALTH OFFICER DETERMINES THAT THE ABOVE NAMED PATIENT SHOULD:

☐ Remain suspended, until successful completion of DMV tests.

☐ Remain suspended, until entered and participating in an alcohol or substance abuse control program and successful completion of DMV tests.

☐ Remain suspended, no DMV tests allowed.

☐ Reinstate driving privileges if otherwise qualified; no medical basis for an immediate suspension.

If applicable:

☐ Require medical re-certification in:

☐ 6 months ☐ 1 year ☐ 2 years

SIGNATURE OF STATE HEALTH OFFICER OR CONTRACT DESIGNEE	DATE
X	