DR 2401 (01/18/19)
COLORADO DEPARTMENT OF REVENUE
Division of Motor Vehicles
P.O. Box 173350
Denver, CO 80217-3350
FAX: (303) 205-8301

Confidential Medical Examination Report

Driver/Patient Section

Patient Last Name	First Name		Middle Initial
Street Address	City	State	ZIP
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)

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 ≥ 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) or Physician's Assistant (PA).** Pursuant to C.R.S. 42-2-112, no civil or criminal action shall be brought against a physician or physician assistant licensed in Colorado for providing a written medical opinion if the physician or physician assistant 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 (circle level if applicable)

☐ N/A ☐ I ☐ II ☐ III ☐ IV

Need Re-examination 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

_____ is:
Patient Name

Recommended license restriction(s):
- ☐ Daylight Driving Only
- ☐ No Highway/Freeway Driving
- ☐ Hand Control
- ☐ Mile Radius Only _____
- ☐ Restricted MPH _____
- ☐ Steering Device
- ☐ Specialty Cushion
- ☐ Foot Device
- ☐ Other_____

Must Choose One
- ☐ Fit to operate a motor vehicle safely.
- ☐ 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.
- ☐ Fitness to drive determination pending; rehab permit required

☐ Patient also requires an eye exam

Specialty (Required)	License Number (Required)	Phone Number (Required)	
Street Address	City	State	ZIP
Patient Last Name	First Name		Middle Initial

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**
- ☐ Alzheimer's Disease
- ☐ Vascular Dementia
- ☐ Frontotemporal or Pick's
- ☐ Dementia (other or unknown)

☐ **Cerebrovascular Disease**
- ☐ Cerebral Infarction or Stroke
- ☐ Hemorrhage or Aneurysm
- ☐ Transient Ischemic Attack
- ☐ Carotid Occlusion or Hypoxia

☐ **Neurological Condition**
- ☐ Brain Injury (open or closed)
- ☐ Tumor or Malformation
- ☐ Parkinson's Disease
- ☐ Multiple Sclerosis

Combined Impairment for Driving
Check (X) 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***
- ☐ Blackout or Syncope*
- ☐ Chronic Sleep Deprivation
- ☐ Sleep Apnea or Narcolepsy
- ☐ Epilepsy or Seizure Disorder
- ☐ Medication Effect
- ☐ Dizziness or Postural Hypotension

☐ Metabolic Condition
- ☐ Diabetes (Type 1 or 2)
- ☐ Thyroid Condition (Hypo or Hyper)
- ☐ Morbid Obesity or Fluid retention

☐ Respiratory Condition
- ☐ Asthma or shortness of Breath
- ☐ COPD
- ☐ Oxygen Dependent

Combined Impairment for Driving
Check (X) 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)

Musculoskeletal, Movement or Neuromuscular

Condition is: ☐ Stable ☐ Progressive ☐ N/A

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

Combined Impairment for Driving
Check (X) 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)

Psychiatric, Emotional or Addiction

Condition is: ☐ Stable ☐ Progressive ☐ N/A

☐ Depression ☐ Bipolar Mood Disorder ☐ Psychosis or Schizophrenia ☐ Alcohol Abuse or Addiction ☐ Drug Abuse or Addition

☐ Suicidal or Homicidal ☐ Anxiety or Post-Traumatic Stress ☐ Chronic Pain (causing distress) ☐ Other _____

Combined Impairment for Driving
Check (X) 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 Name (Printed)	Signature (Required)	Date (MM/DD/YY)