Transportation and Infrastructure Renewal

Driver's Medical Examination Report

NOVA SCOTIA

If you have any questions, please call the Medical Fitness section at **902-424-5732**
Mailing Address: P.O. Box 1652, Halifax, NS, B3J 2Z3 **Fax:** 902-424-0772
Email: medicalfitness@novascotia.ca **Website:** novascotia.ca/sns/rmv/licence/medicals.asp

PART 1: Patient Consent for Physician to Report Medical Information

Name: _____

Address: _____

_____ Postal Code: _____

Driver's Licence Master No.: _ _ _ _ _ _ _ _ _ _ _ _ _ _

Date of Birth (DD/MM/YYYY): _____

Class of licence applied for (check one): ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8

Phone: **Home** (___) _ _ _-_ _ _ _ **Work** (___) _ _ _-_ _ _ _

Cell (___) _ _ _-_ _ _ _

I authorize any physician, hospital or medical clinic to release to the Department any information concerning my medical condition.

_____ _____

PATIENT'S SIGNATURE DATE (DD/MM/YYYY)

PART 2: Vision – Check and complete applicable boxes

VISUAL ACUITY MEETS ACUITY FOR LICENCE CLASS ◯
(With OR without corrective lenses)

Uncorrected R _____ L _____ Both _____

Corrected R _____ L _____ Both _____

◯ **Requires visual correction**

ACUITY: Class 3, 5, 6, 7 and 8 not less than 20/40 (6/12) in better eye.
Class 1, 2 and 4 not less than 20/30 (6/9) in the better eye, poorer eye not less than 20/50 (6/15).

VISUAL FIELD MEETS FIELD FOR LICENCE CLASS ◯

◯ Abnormal. Explain _____

◯ Ocular condition that could affect driving, including colour blindness.

Explain _____

FIELD: Class 3, 5, 6, 7 and 8: 120 degrees horizontal, both eyes opened and examined together.
Class 1, 2 and 4: 120 degrees horizontal in each eye.

MEDICAL PROFESSIONAL DETAILS (if different from PART 5): Name: _____ Date: _____

PART 3: Examination Report – Check "Nothing to Report" or check and complete applicable condition(s)

VASCULAR ***NOTHING TO REPORT*** ◯

☐ 1. Coronary Artery Disease _____

☐ 2. Angina Pectoris _____

Canadian Cardiovascular Society Functional Class

◯ Class 1 ◯ Class 2 ◯ Class 3 ◯ Class 4

☐ 3. Myocardial Infarction: Date _____

☐ 4. Congestive Heart Failure

☐ 5. Arrhythmia: _____

☐ 6. Peripheral Vascular Disease _____

☐ 7. Aneurysm: **Location:**_____ **Size:**_____

☐ 8. Heart Surgery

◯ Angioplasty: Date_____

◯ CABG: Date_____

◯ Pacemaker: Date_____

◯ ICD: Insertion Date _____

Last Discharge Date _____

◯ Transplant: Date_____

◯ LVAD

☐ 9. Other: _____

CENTRAL NERVOUS SYSTEM ***NOTHING TO REPORT*** ◯

☐ 1. CVA/TIA: Date _____

☐ 2. Seizure disorder ◯ Diagnosis of epilepsy.

Date of last seizure _____

Medication required? ◯ YES ◯ NO

☐ 3. Syncope Type:_____

◯ Single Episode: Date_____

◯ Recurrent

☐ 4. Sleep Disorder:

◯ OSA. **Treated?** ◯ YES **How:**_____ ◯ NO

◯ Narcolepsy **Treated?** ◯ YES ◯ NO

☐ 5. Stable Deficit: _____

_____

☐ 6. Progressive Disorder (ALS, Parkinsons, MS):

_____

☐ 7. Vestibular Disorder: _____

☐ 8. Cognitive Impairment: _____

_____

MMSE Score: _____ Date _____
(DD/MM/YYYY)

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Driver's Medical Examination Report

NOVA SCOTIA

Name: _____ Driver's Master No.: _____

Part 3: Examination Report – continued – Check "Nothing to Report" or check and complete applicable condition(s)

RESPIRATORY — *NOTHING TO REPORT* ◯

☐ 1. Respiratory Impairment _____
◯ Mild ◯ Moderate ◯ Severe

☐ 2. Supplemental Oxygen
◯ Occasional ◯ Continuous

METABOLIC — *NOTHING TO REPORT* ◯

☐ 1. Diabetes. Treated by:
◯ Diet ◯ Oral Medication ◯ Insulin
◯ Well controlled ◯ Not well controlled

☐ 2. Severe Hypoglycemia :
Date of last episode _____

☐ 3. Hypoglycemia Unawareness:
Date of last episode _____

☐ 4. Complications Related to Diabetes
◯ Peripheral Vascular ◯ Retinopathy
◯ Neuropathy _____

For all Commercial Drivers or Any Driver if not well controlled

HbA1C Level: _____ Date _____

Blood Glucose: _____ Date _____
(DD/MM/YYYY)

MUSCULOSKELETAL — *NOTHING TO REPORT* ◯

☐ 1. Amputation: _____

☐ 2. Weakness: _____

☐ 3. Impaired range of motion: _____

PSYCHIATRIC — *NOTHING TO REPORT* ◯

☐ 1. Psychosis

☐ 2. Personality Disorder

☐ 3. Severe depression or anxiety

☐ 4. Other: _____

RENAL DISEASE — *NOTHING TO REPORT* ◯

☐ 1. Dialysis

☐ 2. Transplant: Date _____

☐ 3. Nephropathy

SUBSTANCE USE/ABUSE — *NOTHING TO REPORT* ◯

☐ 1. Alcohol Abuse
◯ Under control Since: _____
◯ Not controlled

☐ 2. Alcohol Related Seizure: Date _____

☐ 3. Drug Abuse
◯ Substance: _____
◯ Under control
◯ Not controlled

MEDICATION — *NOTHING TO REPORT* ◯

☐ 1. List medication(s) that could cause impairment:

_____

_____

_____

HEARING — *NOTHING TO REPORT* ◯

☐ 1. Significant Hearing Loss. **Corrected?** ◯ YES ◯ NO
(Classes 1 – 4 only)
Perceives a forced whispered voice at not less than 5 feet (1.5 metres) with or without the use of a hearing aid or, hearing loss no greater than 40dB averaged at 500, 1000, and 2000 Hz in their better ear

OTHER CONDITIONS — *NOTHING TO REPORT* ◯

(that may affect driving)

☐ 1. General Debility

☐ 2. Other _____

Part 4: Opinion and Recommendations

PHYSICIAN'S STAMP

ISSUE LICENCE AS APPLIED FOR ◯

OR:

☐ 1. Issue licence with restrictions: _____

_____

☐ 2. Road test required

☐ 3. Suspend licence pending: _____

☐ 4. Suspend – unlikely to improve

Part 5: Medical Professional Details

☐ Family Physician, for _____ years

☐ Walk in or Locum **Chart Reviewed** ◯ YES ◯ NO

☐ Specialist

☐ Nurse Practitioner

Name: _____

Address _____

_____ Postal Code: _____

PHONE ( ) _____ FAX ( ) _____

_____ _____
SIGNATURE DATE (DD/MM/YYYY)

REV 02/17 REP 32