

# Private and Commercial Vehicle Driver's Health Assessment



Transport Operations (Passenger Transport) Act 1994,  
Transport Operations Road Use Management) Act 1995,  
Tow Truck Act 1973.

## Important information

This form is provided to assist your treating health professional to assess whether you have a mental or physical incapacity (a **medical condition**) that is likely to adversely affect your ability to drive a motor vehicle safely. This assessment should be conducted in accordance with the National Medical Standards (private or commercial) as set out in the guidelines, *Assessing Fitness to Drive - Commercial and Private Vehicle Drivers* (the **AFTD**).

- When making an appointment, you should tell your health professional why you are making the appointment because this kind of medical assessment may take longer than a standard consultation.
- Prior to the medical assessment, you should complete the Health Questionnaire *below*.
- If you need to wear glasses/ contact lenses/ hearing aids when driving, take them with you to the assessment.
- At the assessment, give this form to your health professional who will complete the form and retain it for records purposes.
- After the assessment, your health professional will complete the **Medical Certificate for Motor Vehicle Driver** form (F3712) and then give the form to you so that you may give the form to the Department of Transport and Main Roads (the department).

The payment for the medical assessment and any associated costs is your responsibility.

## Health Questionnaire - Applicant to complete

(this form will be kept by your health professional)

### 1. Personal details (please PRINT)

Family name

Given name/ s

Gender

Male

Female

Date of birth

 /  / 

Driver licence number (if known)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------

State/ territory/ country of issue

**Please answer the following questions by ticking the applicable box. If you are unsure of a question, ask your health professional what it means before answering. Your health professional may ask you additional questions during the assessment.**

- |                                                                                                | No                       | Yes                      |
|------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. Are you currently being treated by a health professional for any illness or injury?         | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you use any drugs or medications prescribed by a health professional?                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you use any drugs or medication <b>not</b> prescribed by a health professional?          | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever had, or been told by a health professional that you had any of the following? | No                       | Yes                      |
| 4.1 High blood pressure                                                                        | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.2 Heart disease                                                                              | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.3 Chest pain, angina                                                                         | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.4 Any condition requiring heart surgery                                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.5 Palpitations/ Irregular heartbeat                                                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.6 Abnormal shortness of breath                                                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.7 Head injury/ Spinal injury                                                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.8 Seizures, fits, convulsions, epilepsy                                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.9 Blackouts, fainting                                                                        | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.10 Stroke                                                                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.11 Dizziness, vertigo, problems with balance                                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.12 Double vision, difficulty seeing                                                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.13 Colour blindness                                                                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.14 Kidney disease                                                                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.15 Diabetes                                                                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.16 Neck, back or limb disorders                                                              | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.17 Hearing loss or deafness                                                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.18 Psychiatric illness or nervous disorder                                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.19 Sleep disorder, sleep apnoea or narcolepsy                                                | <input type="checkbox"/> | <input type="checkbox"/> |

- |                                                                                                           | No                                             | Yes                                   |
|-----------------------------------------------------------------------------------------------------------|------------------------------------------------|---------------------------------------|
| 5. Have you ever had an ear operation, or do you use a hearing aid?                                       | <input type="checkbox"/>                       | <input type="checkbox"/>              |
| 6. Have you ever had any serious injury, illness, operation, or been in hospital for any reason?          | <input type="checkbox"/>                       | <input type="checkbox"/>              |
| 7. Has anyone noticed that your breathing stops or is disrupted by episodes of choking during your sleep? | <input type="checkbox"/>                       | <input type="checkbox"/>              |
| 8. How frequently do you drink alcohol?                                                                   |                                                |                                       |
|                                                                                                           | Daily <input type="checkbox"/>                 | Occasionally <input type="checkbox"/> |
|                                                                                                           | 2 to 3 times per week <input type="checkbox"/> | Never <input type="checkbox"/>        |

### 2. Applicant's declaration and consent

(Please sign in the presence of the treating health professional)

I declare that I have read all my answers I have given to the questions on this form about my personal details and that the answers given by me about my personal details are complete, true and correct in every detail.

I also declare that the information given to my treating health professional during this assessment is, to the best of my knowledge, true and correct.

I consent to the examining health professional releasing relevant medical information to the department, or a health professional nominated by the department, in order to determine my medical eligibility for the class and/ or type of driver licence or industry authority currently held or applying for, in accordance with the National Medical Standards (private or commercial) as set out in the AFTD guidelines.

I understand that I may be prosecuted for giving or stating any false or misleading information.

Applicant's signature

Date

 /  / 

**Privacy Statement:** The information on this form is required to assist a health professional to assess whether or not a person has a medical condition that is likely to adversely affect the person's ability to drive a motor vehicle safely. This assessment is to be conducted according to the National Medical Standards (Private or Commercial) as set out in the *Assessing Fitness to Drive* guidelines. The collection of this information is under the relevant Acts nominated on this form.

**Important—** For privacy reasons, the completed examination proforma **must not** be returned to the department. Medical information relevant to the department should be included on the Medical Certificate (*in the case of department initiated examinations*) or on the Medical Condition Notification form (*for assessments made in the course of patient treatment*).

**Clinical Examination for Health Professional's Use and Retention for record purposes only**

**Applicant's details**

Applicant's/ driver's full name (please PRINT)

Applicant's/ driver's address

  


Postcode

The examining health professional will be guided by findings in the questionnaire or a referral letter and may apply appropriate tests other than those outlined here ie. the Mini Mental State or equivalent for cognitive conditions. This form is to be retained by the examining health professional and not returned to the department. Findings relevant to the person's fitness to drive should be recorded on the medical certificate supplied by the department.

**1. Cardiovascular system**

**1.1 Blood pressure—** (repeat if necessary)

Systolic  mmHg  mmHg

Diastolic  mmHg  mmHg

**1.2 Pulse rate**..... Regular  Irregular

**1.3 Heart sounds**..... Normal  Abnormal

**1.4 Peripheral pulses**..... Normal  Abnormal

**2. Chest/ Lungs**

**2.1 Chest/ Lungs**..... Normal  Abnormal

**3. Abdomen (Liver)**

**3.1 Abdomen (Liver)**..... Normal  Abnormal

**4. Neurological/ Locomotor**

**4.1 Cervical spine rotation**.... Normal  Abnormal

**4.2 Back movement**..... Normal  Abnormal

**4.3 Upper limbs**

(a) Appearance..... Normal  Abnormal

(b) Joint movements..... Normal  Abnormal

**4.4 Lower limbs**

(a) Appearance..... Normal  Abnormal

(b) Joint movements..... Normal  Abnormal

**4.5 Reflexes**..... Normal  Abnormal

**4.6 Romberg's sign**..... Normal  Abnormal

*A pass requires the ability to maintain balance while standing with shoes off, feet together side by side, eyes closed and arms by sides, for 30 seconds.*

**5. Vision**

**5.1 What is your assessment of the person's visual acuity?**

R 6 /	L 6 /	Binocular 6 /
-------	-------	---------------

**5.2 Does this person need to wear glasses or contact lenses for driving?** No  Yes

**5.3 Visual fields**..... Normal  Abnormal   
*(confrontation to each eye)*

**6. Hearing** (Commercial vehicle drivers only)

**6.1 Hearing**..... Normal  Abnormal

**7. Urinalysis**

**7.1 Protein**..... Normal  Abnormal

**7.2 Glucose**..... Normal  Abnormal

**8. Neuropsychological assessment**

Where clinically indicated, apply the Mini Mental State Questionnaire or General Health Questionnaire or equivalent.

**8.1 Score**.....

**9. Relevant clinical findings**

Note comments on any relevant findings detected in the questionnaire or examination, making reference to the requirements of the standards outlined in the AFTD guidelines.

  
  
  


**10. Assessment**

**What type of licence/ industry authority is the applicant applying for?**

Private  Commercial

Health Examiner's full name (please PRINT)

Signed

Date of examination

 /  / 

The health professional is to complete the 'Medical Certificate for Motor Vehicle Driver' (form F3712) in accordance with the National Medical Standards (private or commercial) as set out in the AFTD guidelines.

**Important—** For privacy reasons, the completed examination proforma **must not** be returned to the department. Medical information relevant to the department should be included on the Medical Certificate (in the case of department initiated examinations) or on the Medical Condition Notification form (for assessments made in the course of patient treatment).