MEDICAL FORM
P-142M Rev. 7-18

STATE OF CONNECTICUT
DEPARTMENT OF MOTOR VEHICLES
60 STATE STREET, WETHERSFIELD, CT 06161-1013
DRIVER SERVICES DIVISION
ct.gov/dmv

☐ Department of Rehabilitation Services/ Driver Training Program Referral

This patient has been referred to the DMV concerning his or her ability to safely operate a motor vehicle.

INSTRUCTIONS

- Patient: Complete section (A).
- Medical examiner(s) (licensed physician, PA or APRN): Complete section (B) and any applicable subsection of section (C) based on the results of a personal examination conducted within 90 days of the completion of this report. Attach other information as necessary, including any technical reports or test results.

Submission of this report to the DMV is authorized pursuant to Section 14-46 of the Connecticut General Statutes and no civil action may be brought against any person who, in good faith, provides a report. Based upon all available information, DMV will make a final decision concerning the patient's ability to hold an operator's license.

Section (A): Patient Information

NAME *(Last, First, Middle)*	**DATE OF BIRTH**	**OPERATOR'S LICENSE NUMBER**

MAILING ADDRESS *(Street)*	*(City)*	*(State)*	*(Zip Code)*	**PATIENT PHONE NUMBER**

I hereby authorize and accept that my medical examiner will conduct a medical examination to determine my fitness to operate a motor vehicle safely and may submit copies of my medical records to the DMV and/or the Department of Rehabilitation Services.

SIGNATURE OF DRIVER/PATIENT	**DATE**
X	

BELOW TO BE COMPLETED BY MEDICAL EXAMINER.

Section (B): Clinical Information and Safety Implications

EXAMINATION DATE	**ADDRESS INCIDENT OF** *Use space below*	**Are you a regular or primary care provider for this patient?** ☐ **YES** ☐ **NO**

PLEASE INDICATE BELOW ANY PRESENT CONDITIONS THAT MAY AFFECT THIS PATIENT'S ABILITY TO DRIVE SAFELY AND/OR ADDRESS INCIDENT DATE NOTED ABOVE.

The person named above is NOT medically qualified to operate a motor vehicle. ☐

Do you believe this person should be required to complete a DMV road test to determine driving ability? ☐ **YES** ☐ **NO**

DMV may require periodic reporting to ensure there has been no change in a patient's ability to drive safely. Considering this patient's condition, should periodic reports be submitted to DMV? ☐ **YES** ☐ **NO**

If yes, for which condition(s) should the patient provide a report: _____

How often should a report be filed? Every _____ **months for** _____ **year(s).**

Is this patient's movement limited? ☐ **YES** ☐ **NO**

Does this patient's condition require that he or she operate a vehicle with special equipment? ☐ **YES** ☐ **NO If yes, what equipment?**

Should this patient be limited to operating a motor vehicle with any of the following restrictions?

☐ **MECHANICAL AID (C)** ☐ **PROSTHETIC AID (D)** ☐ **AUTOMATIC TRANSMISSION (E)**

I certify that I have personally examined this patient within the 90 days preceding the completion of this report. I swear or affirm under penalty of deliberate false statement in accordance with Connecticut General Statutes §14-110 and §53a-157b, that the above information and any attachment hereto is true and correct.

MEDICAL EXAMINER'S NAME	**MEDICAL EXAMINER'S SIGNATURE**	**LICENSE NUMBER**	**SPECIALTY**
	X		

TELEPHONE NUMBER	**DATE**

Section (C): Condition-Specific Information *(Continued on Page 2)*

CARDIOLOGY

Patient has no known cardiac condition ☐

Abnormalities on cardiac examination: _____

Has patient suffered lost or altered consciousness? ☐ **YES** ☐ **NO If yes, on what date(s)?** _____

List any known medication, which may produce side-effects, that may impact a patient's ability to safely operate a motor vehicle. Include dosage:

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MEDICAL EXAMINER'S NAME	**MEDICAL EXAMINER'S SIGNATURE**	**LICENSE NUMBER**	**SPECIALTY**
	X		

TELEPHONE NUMBER	**DATE**

LICENSE NUMBER: _____

DIABETES/METABOLIC

Patient has no known diabetic/metabolic condition ☐

Is patient on insulin treatment? ☐ YES ☐ NO Does this patient suffer from severe hypoglycemia? ☐ YES ☐ NO

Has patient suffered lost or altered consciousness? ☐ YES ☐ NO If yes, on what date(s)? _____

Is there significant neuropathy? ☐ YES ☐ NO If yes, does it affect motor vehicle operation? ☐ YES ☐ NO

Has patient suffered retinopathy to the point of vision loss? ☐ YES ☐ NO

List any known medication, which may produce side-effects, that may impact a patient's ability to safely operate a motor vehicle. Include dosage:

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MEDICAL EXAMINER'S NAME	MEDICAL EXAMINER'S SIGNATURE X	LICENSE NUMBER	SPECIALTY
TELEPHONE NUMBER	DATE		

NEUROLOGY

Patient has no known neurological condition ☐

Name(s) of specific neurological condition(s) present:

State episodes of lost or altered consciousness or awareness within the past two years:

Date: _____ Cause: _____ Date: _____ Cause: _____ Date: _____ Cause: _____

Provide the following medication information relevant to safe operation of a motor vehicle:

DATE OF LAB WORK	TYPE/DOSE	BLOOD LEVEL

I certify that I have personally examined this patient within the 90 days preceding the completion of this report. I swear or affirm under penalty of deliberate false statement in accordance with Connecticut General Statutes §14-110 and §53a-157b, that the above information and any attachment hereto is true and correct.

MEDICAL EXAMINER'S NAME	MEDICAL EXAMINER'S SIGNATURE X	LICENSE NUMBER	SPECIALTY
TELEPHONE NUMBER	DATE		

PSYCHIATRIC/SUBSTANCE ABUSE

Patient has no known psychiatric/substance abuse condition ☐

Name(s) of specific psychiatric condition(s) present: _____

Do you have reason to suspect the patient abuses alcohol, illicit drugs or medication? ☐ YES ☐ NO

If yes, please explain: _____

Does this patient suffer from convulsive seizures? ☐ YES ☐ NO Date of last episode: _____

List any known medication, which may produce side-effects, that may impact a patient's ability to safely operate a motor vehicle. Include dosage:

I certify that I have personally examined this patient within the 90 days preceding the completion of this report. I swear or affirm under penalty of deliberate false statement in accordance with Connecticut General Statutes §14-110 and §53a-157b, that the above information and any attachment hereto is true and correct.

MEDICAL EXAMINER'S NAME	MEDICAL EXAMINER'S SIGNATURE X	LICENSE NUMBER	SPECIALTY
TELEPHONE NUMBER	DATE		

RESPIRATORY/SLEEP DISORDERS

Patient has no known respiratory/sleep disorder condition ☐

Name(s) of specific respiratory/sleep disorder condition(s) present: _____

Does the patient require use of a CPAP machine? ☐ YES ☐ NO Is the patient compliant with the use of the CPAP machine? ☐ YES ☐ NO

Is this patient able to exhale 1000CC of air in one continuous breath during the operation of an ignition interlock device? ☐ YES ☐ NO

List any known medication, which may produce side-effects, that may impact a patient's ability to safely operate a motor vehicle. Include dosage:

I certify that I have personally examined this patient within the 90 days preceding the completion of this report. I swear or affirm under penalty of deliberate false statement in accordance with Connecticut General Statutes §14-110 and §53a-157b, that the above information and any attachment hereto is true and correct.

MEDICAL EXAMINER'S NAME	MEDICAL EXAMINER'S SIGNATURE X	LICENSE NUMBER	SPECIALTY
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