Queensland Government

Private and Commercial Vehicle Driver's Health Assessment

Transport Operations (Passenger Transport) Act 1994
Transport Operations (Road Use Management) Act 1995

Important information

This form is provided to guide your treating doctor's assessment of your medical fitness to drive. This assessment should be conducted in accordance with the national medical standards as set out in the Austroads *Assessing Fitness To Drive for Commercial and Private Vehicle Drivers* publication (AFTD).

- When making your appointment to see your treating doctor, we recommend that you advise the reason for your visit so that an appropriate length appointment can be made for you.
- It is recommended that you complete the health questionnaire below prior to attending your appointment.
- If you need to wear glasses/contact lenses/hearing aids when driving, take them with you to the assessment.
- At the beginning of your appointment, give this form to your treating doctor who will complete the rest of the form and retain it for their records.
- After the assessment, your health professional will complete the *Medical Certificate for Motor Vehicle Driver* (form F3712) for you to present to the Department of Transport and Main Roads (the department).

Your treating doctor's fees are set at their discretion and you are responsible for the payment of these fees.

Part 1 - Health Questionnaire - to be completed by the patient (this form will be kept by the health professional)

1. Personal details (please print)

Family name

Given name/s

Date of birth (/ /)

State/territory/country of issue

Driver licence number (if known)

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?	☐	☐
2. Do you use any drugs or medications prescribed by a health professional?	☐	☐
3. Do you use any drugs or medications not prescribed by a health professional?	☐	☐
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	☐	☐
4.2 Heart disease	☐	☐
4.3 Chest pain, angina	☐	☐
4.4 Any condition requiring heart surgery	☐	☐
4.5 Palpitations/Irregular heartbeat	☐	☐
4.6 Abnormal shortness of breath	☐	☐
4.7 Head injury/Spinal injury	☐	☐
4.8 Seizures, fits, convulsions, epilepsy	☐	☐
4.9 Blackouts, fainting	☐	☐
4.10 Stroke	☐	☐
4.11 Dizziness, vertigo, problems with balance	☐	☐
4.12 Double vision, difficulty seeing	☐	☐
4.13 Colour blindness	☐	☐
4.14 Kidney disease	☐	☐
4.15 Diabetes	☐	☐
4.16 Neck, back or limb disorders	☐	☐
4.17 Hearing loss or deafness	☐	☐
4.18 Psychiatric illness or nervous disorder	☐	☐
4.19 Sleep disorder, sleep apnoea or narcolepsy	☐	☐

	No	Yes
5. Have you ever had an ear operation, or do you use a hearing aid?	☐	☐
6. Have you ever had any serious injury, illness, operation, or been in hospital for any reason?	☐	☐
7. Has anyone noticed that your breathing stops or is disrupted by episodes of choking during your sleep?	☐	☐

8. How frequently do you drink alcohol?

Daily ☐ Occasionally ☐

Two-three times per week ☐ Never ☐

2. Patient declaration

I declare that the information I have provided on this form for my treating doctor is true and complete.

Patient's signature

Date (/ /)

Important: Please do not send this completed assessment to the department as it should be retained by the treating doctor and form part of your medical file. Your treating doctor's recommendation regarding your medical fitness to drive should be recorded on the *Medical Certificate for Motor Vehicle Driver* (form F3712).

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Part 2 - Clinical Examination - to be completed by the treating doctor

Patient's details

Family name (please print)

Given name/s

Residential address

Postcode

Please be guided by the information your patient has provided in Part 1 - Health Questionnaire. You may apply appropriate tests other than those outlined here i.e. mini mental state, or equivalent for cognitive conditions.

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

Which standard did you assess your patient against in the AFTD?

Private ☐ Commercial ☐

Treating doctor's full name (please print)

Signature

Date of examination

/ /

Your recommendation regarding your patient's medical fitness to drive should be provided on the *Medical Certificate for Motor Vehicle Driver* (form F3712).

Important: Please do not send this completed assessment to the department as it should be retained by you and form part of your patient's medical file. Your recommendation regarding your patient's medical fitness to drive should be recorded on the *Medical Certificate for Motor Vehicle Driver* (form F3712).