

THE FORM SHOULD BE COMPLETED BY THE EXAMINING HEALTH PROFESSIONAL AND PROVIDED TO THE REQUESTING ORGANISATION/DRIVER

A COPY SHOULD BE RETAINED BY THE EXAMINING HEALTH PROFESSIONAL

### Assessing Fitness to Drive 2016

## Health Assessment for Commercial Vehicle Driver

# FITNESS TO DRIVE REPORT

(Note: this report relates to the driver's fitness for duty and is not to be used for driver licensing assessments)

|                                  |                |                       |                 |  |
|----------------------------------|----------------|-----------------------|-----------------|--|
| <b>Driver information:</b>       | Surname:       |                       | Given name(s):  |  |
| Address:                         |                |                       |                 |  |
| Phone:                           | Date of birth: | Driver Licence no.    | State of issue: |  |
| <b>Employer information:</b>     | Name:          |                       |                 |  |
| Address:                         |                | Contact phone number: |                 |  |
| <b>Nature of driving duties:</b> |                |                       |                 |  |
|                                  |                |                       |                 |  |

|  |  |
|--|--|
| <b>Assessment outcome:</b>   |  |
| I was familiar with the driver's medical history before conducting this assessment   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| I have sighted the driver's licence  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <p><b>I have examined the driver in accordance with Assessing Fitness to Drive 2016 standards for commercial vehicle drivers, and in my opinion the driver (tick ONE box from 1 to 4 and indicate recommended management):</b></p> <p><input type="checkbox"/> <b>1. <u>Unconditionally</u> meets the medical criteria for fitness to drive</b><br/>Meets all relevant medical criteria. No restrictions or conditions. See recommended date of next review below.</p> <p><input type="checkbox"/> <b>2. <u>Conditionally</u> meets the medical criteria for fitness to drive</b><br/>Has a medical condition that may impact on fitness to drive, but it is well controlled and meets the <b>conditional</b> criteria in <i>Assessing Fitness to Drive 2016</i>. May require person to be more frequently reviewed than prescribed under normal periodic review. See recommended date of next review below.<br/>Person is required to wear the following aids/devices:<br/><input type="checkbox"/> Corrective lenses <input type="checkbox"/> Hearing aid <input type="checkbox"/> Other aids/devices (specify):</p> <p><input type="checkbox"/> <b>3. <u>Temporarily</u> does not meet the medical criteria for fitness to drive</b><br/>Does not meet relevant medical criteria (Unconditional or Conditional) and should not undertake normal driving duties. May perform alternative tasks. May return to driving following: an improvement in condition, response to treatment or confirmed diagnosis of undifferentiated illness.</p> <p><input type="checkbox"/> <b>4. <u>Permanently</u> does not meet the medical criteria for fitness to drive</b><br/>Does not meet relevant medical criteria and cannot perform normal driving duties in the foreseeable future.</p> |  |
| <p><b>Recommended management:</b></p> <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Local doctor referral<br/> <input type="checkbox"/> Specialist referral<br/> <input type="checkbox"/> Laboratory tests<br/> <input type="checkbox"/> Drug test<br/> <input type="checkbox"/> Practical driver test         </div> <div> <input type="checkbox"/> More frequent periodic review (see recommended review date below)<br/> <input type="checkbox"/> Other, please describe (Please attached additional information to the form if required)         </div> </div>   |  |

**Recommended date of next review (from date of assessment):**

☐ 1 year ☐ 2 years ☐ 3 years ☐ 4 years ☐ 5 years ☐ Other (specify)

**Health professional's details**

|                   |                     |            |
|-------------------|---------------------|------------|
| Name:             | Phone:              | Facsimile: |
| Practice address: |                     |            |
| Signature:        | Date of assessment: |            |