GOVERNMENT OF DUBAI

هـيئـــة الصــحــة بدبــي
DUBAI HEALTH AUTHORITY

FITNESS TO DRIVE
MEDICAL EXAMINATION REPORT
MEDICAL FITNESS CENTER
DUBAI HEALTH AUTHORITY

To be filled in by the Doctor. The patient must fill in sections 9 and 10 in the doctor's presence (please use black ink).

- Before filling in this form, please read Section B (page5) of the Information and useful notes booklet (INF4D).
- Please ensure you fully examine the patient as well as taking the patients history.
- Please answer all questions.

PATIENTS NAME: ______________________________ **HC#:** ________________
BP: _________ **RR:** _______**PR:** _______ **TEMP:** _____ **HbA1C:** ___________
WEIGHT: ______ **(KG) HEIGHT**: _______ **(CM)**

PATIENTS HISTORY

Details of smoking habits, if any:

- How many years client is smoking? ________________________
- How many sticks/packs per day? ________________________

Details of taking alcohol, if any

- Number of alcohol units taken each week

History of any disease?
If yes please indicate: ____
Date when first licensed to drive: ______________________
Which type of vehicle you are driving? ____________________

I. VISION ☐ ***YES*** ☐ ***NO***

Please tick √ the appropriate box (es)

1. Is the visual acuity at least 6/9 in the better eye and at least 6/12 in the other? (Corrective lenses may be worn) as measured with the full size 6m Snellen chart
2. Do corrective lenses have to be worn to achieve this standard?
   If **YES**, is the:
   a. uncorrected acuity at least 3/60 in the right eye?
   b. uncorrected acuity at least 3/60 in the left eye?
   (3/60 being the ability to read the 6/60 line of the full size 6m Snellen chart at 3 metres)
   c. correction well tolerated?
3. Please state the visual acuities of each eye in terms of the 6m Snellen Chart.
   Please convert any 3 metre readings to the 6 metre equivalent

UNCORRECTED		CORRECTED	
Right	**Left**	**Right**	**Left**

4. Is there a defect in the patient's binocular field of vision (central and/or peripheral)?
5. Is there diplopia? (Controlled or uncontrolled)?

6. Does the patient have any other ophthalmic condition?

If **YES** to 4, 5 or 6 please give details in Section 7 and enclose any relevant visual field charts or hospital letters.

II. NERVOUS SYSTEM ☐***YES*** ☐***NO***

1. Has the patient had any form of epileptic attack?
   If **YES**, Please answer questions a-f
   a. Has the patient had more than one attack?
   b. Please give date of first and last attack
      FIRST ATTACK: **LAST ATTACK:**
   c. Is the patient currently on anti-epilepsy medication?
      If **YES**, please fill in current medication on the appropriate section on the front of this form.
   d. If no longer treated, please give date when treatment ended
   e. Has the patient had a brain scan? If **YES**, please state:
      MRI Date: CT Date:
      Please supply reports if available
   f. Has the patient had an EEG?
      If **YES** to any of above, please supply reports if available.
2. Is there a history of blackout or impaired consciousness within the last 5 years?
   If **YES**, please give date(s) and details in Section 7
3. Is there a history of, or evidence of, any of the conditions listed at a-g below?
   If **NO**, got to **Section 3.**
   If **YES,** please tick the relevant box (es) and give dates and full details at **Section 7** and supply any relevant reports.
   a. Stroke or TIA please delete as appropriate
   If **YES**, please give date Has there been a full recovery?
   Please provide copies of any carotid artery and/or other major cerebral artery imaging reports.
   b. Sudden and disabling dizziness/vertigo within the last 1 year with a liability to recur
   c. Subarachnoid hemorrhage
   d. Serious head injury within the last 10 years
   e. Brain tumor, either benign or malignant, primary or secondary
   f. Other brain surgery or abnormality
   g. Chronic neurological disorders e.g. Parkinson's disease, Multiple Sclerosis

III. DIABETIS MELLITUS ☐***YES*** ☐***NO***

1. Does the patient have diabetes mellitus?

If **NO**, please go to **Section 4**

If **YES,** please answer the following questions.

2. Is the diabetes managed by:

a. Insulin?
If **YES**, please give date started on insulin
b. If treated with insulin are there at least 3 months of blood glucose readings stored on a memory meter?
c. Other injectable treatments?
d. A sulphonylurea or Glinide?
e. Oral hypoglycemic agents and diet?
If **YES**, please fill in current medication on the appropriate section on the front of this form
f. Diet only?

3. a. Does the patient test blood glucose at least twice every day?
b. Does the patient test at times relevant to driving?
c. Does the patient carry fast acting carbohydrate in the vehicle when driving?
d. Does the patient have a clear understanding of diabetes and the necessary precautions for safe driving?
4. Is there evidence of:
a. Loss of visual field?
b.Severe peripheral neuropathy, sufficient to impair limb function for safe driving?
5. Is there any evidence of impaired awareness of hypoglycemia?
6. Has there been laser treatment for retinopathy or intra-vitreal treatment for retinopathy?
If **YES**, please give date(s) of treatment
7. Is there a history of hypoglycemia in the last 12months requiring the assistance of another person?
If **YES** to any of 4-6 above, please give details in **Section 7**

IV. PSYCHIATRIC ILLNESS ☐***YES*** ☐***NO***

Is there a history of, or evidence of, any of the conditions listed at 1-7 below?
If **NO**, please go to **Section 5**
If **YES**, please tick the relevant box (es) below and give date(s), prognosis, period of stability and details of medication, dosage and any side effects in **Section 7**.

NB. Please enclose relevant hospital notes

NB. If patient remains under specialist clinic(s), ensure details are filled in at the top of page 1.

1. Significant psychiatric disorder within the past 6months
2. A psychotic illness within the past 3 years, including psychotic depression
3. Dementia or cognitive impairment
4. Persistent alcohol misuse in the past 12 months
5. Alcohol dependence in the past 3 years
6. Persistent drug misuse in the past 12months
7. Drug dependence in the past 3 years

V. CARDIAC

V.A CORONARY ARTERY DISEASE □***YES*** □***NO***

Is there a history of, or evidence of, Coronary Artery Disease?
If **NO**, go to **Section 5B**
If **YES,** please answer all questions below and give details at **Section 7** of the form and enclose relevant hospital notes.

1. Acute Coronary Syndromes including Myocardial Infarction?
   If **YES**, please give date (s)
2. Coronary artery by-pass graft surgery?
   If **YES,** please give date (s)
3. Coronary Angioplasty (P.C.I)
   If **YES,** please give date of most recent intervention
4. Has the patient suffered from Angina?
   If **YES,** please give the date of the last known attack

V.B CARDIAC ARRHYTHMIA □***YES*** □***NO***

Is there a history of, evidence of cardiac arrhythmia?
If **NO**, go to **Section 5C**
If **YES**, please answer all questions below and give details in **SECTION 7** of the form.

1. Has there been a significant disturbance of cardiac rhythm? i.e. Sinoatrial disease, significant atrio-ventricular conduction defect, atrial flutter/fibrillation, narrow or broad complex tachycardia in last 5 years
2. Has the arrhythmia been controlled satisfactorily for at least 3months?
3. Has an ICD or biventricular pacemaker (CRST-D type) been implanted?
4. Has a pacemaker been implanted?
   If **YES:**
   a. Please supply date of implantation
   b. Is the patient free of symptoms that caused the device to be fitted?
   c. Does the patient attend a pacemaker clinic regularly?

V.C PERIPHERAL ARTERIAL DISEASE (EXCLUDING BUERGER'S DISEASE) AORTIC ANUERYSM/DISSECTION □***YES*** □***NO***

Is there a history or evidence of ANY of the following?
If **YES**, please tick √ ALL relevant boxes below, and give details in **Section 7** of the form.
If **NO**, got to **Section 5D**

1. **PERIPHERAL ARTERIAL DISEASE** (excluding Buerger's Disease)
2. Does the patient have claudication?
   If **YES**, for how long in minutes can the patient walk at a brisk pace before being symptom-limited?
   Please give details
3. **AORTIC ANEURYSM**
   IF **YES:**
   a. Site of Aneurysm: Thoracic Abdominal
   b. Has it been repaired successfully?

c. Is the transverse diameter currently >5.5cms?

If **NO**, please provide latest measurement and date obtained

4. **DISSECTION OF THE AORTA REPAIRED SUCCESSFULLY:**
   If **YES,** Please provide copies of all reports to include those dealing with any surgical treatment.

V.D VALVULAR/CONGENITAL HEART DISEASE ☐***YES*** ☐***NO***

Is there a history of, or evidence of, valvular/congenital heart disease?
If **NO**, go to **Section 5E**
If **YES,** please answer all questions below and give details in **Section 7** of the form.

1. Is there a history of congenital heart disorder?
2. Is there a history of heart valve disease?
3. Is there any history of embolism? (not pulmonary embolism)
4. Does the patient currently have significant symptoms?
5. Has there been any progression since the last license application? (if relevant)

V.E CARDIAC OTHER ☐***YES*** ☐***NO***

Does the patient have a history of **ANY** of the following conditions?

a. a history of, or evidence of, heart failure?
b. Established cardiomyopathy?
c. A heart or heart/lung transplant?
d. Untreated atrial myxoma

If **YES**, please give full details in **Section 7** of the form. If **NO,** go to **Section 5F**

V.F CARDIAC INVESTIGATIONS ☐***YES*** ☐***NO***

This section must be filled in for all patients

1. Has a resting **ECG** been undertaken?
   If **YES,** does it show:
   a. Pathological Q waves?
   b. Left bundle branch block?
   c. Right bundle branch block?

   Please provide a copy of the ECG report (if available) or comment at Section 7
2. Has an exercise ECG been undertaken (or planned)?
   If **YES,** please give date _____________ and give details in **Section 7**
   Please provide relevant reports if available
3. Has an echocardiogram been undertaken (or planned)?
   a. If **YES,** please give date ______________ and give details in **Section 7**
   b. If undertaken, is/was the left ventricular ejection fraction greater than or equal to 40%?

   Please provide relevant reports if available
4. Has a coronary angiogram been undertaken (or planned)?
   If **YES**, please give date ______________ and give details in **Section 7**
   Please provide relevant reports if available
5. Has a 24 hour ECG tape been undertaken (or planned)?
   If **YES,** please give date ______________ and give details in **Section 7**
   Please provide relevant reports if available

6. Has a Myocardial Perfusion Scan or Stress Echo study been undertaken) or planned)?
   If **YES,** please give details date **_____________** and give details in **Section 7**
   Please provide relevant reports if available

V.G BLOOD PRESSURE ***YES*** ***NO***

This section must be filled in for all patients

1. Is today's best systolic pressure reading 180mm Hg or more?
2. Is today's best diastolic pressure reading 100mm Hg or more?
   Please give today's reading
3. Is the patient on anti-hypertensive treatment?
   If **YES** to any of the above, please provide three previous readings with dates, if available

VI. GENERAL ***YES*** ***NO***

Please answer all questions in this section. If your answer is **YES** to any of the questions, please give full details in **Section 7.**

1. Is there currently a disability of the spine or limbs to impair control of the vehicle?
2. a. Is there a history of bronchogenic carcinoma or other malignant tumour, for example, malignant melanoma, with a significant liability to metastasize cerebrally?
   If **YES,** please give dates and diagnosis and state whether there is current evidence of dissemination
   b. Is there any evidence the patient has a cancer that causes fatigue or cachexia that affects safe driving?
3. Is the patient profoundly deaf?
   If **YES**, is the patient able to communicate in the event of an emergency by speech or by using a device, e.g. a textphone?
4. Does the patient have a history of alcoholic liver disease and/or liver cirrhosis of any origin?
   If **YES,** please give details in **Section 7**
5. Is there a history of, or evidence of, sleep apnoea syndrome?
   If **YES**, pleas provide details
   a. Date of diagnosis
   b. Is it controlled successfully?
   c. If **YES**, please state treatment **___________**
   d. Please state period of control
   e. Please provide neck circumference
   f. Please provide girth measurement in cms
   g. Date last seen by consultant
6. Does the patient suffer from narcolepsy or cataplexy?
   If **YES,** please give details in **Section 7**
7. Is there any other Medical Condition causing excessive daytime sleepiness?
   If **YES**, please provide details
   a. Diagnosis
   b. Date of diagnosis
   c. Is it controlled successfully?
   d. If **YES,** please state treatment
   e. Please state period of control
   f. Date last seen by consultant
8. Does the patient have severe symptomatic respiratory disease causing chronic hypoxia?

9. Does any medication currently taken cause the patient side effects that could affect safe driving?
   If **YES,** please provide details of medication and symptoms
10. Does the patient have any other medical condition that could affect safe driving?
   If **YES,** please provide details

VII. PLEASE FORWARD COPIES OF RELEVANT HOSPITAL NOTES ONLY. PLEASE DO NOT SEND ANY NOTED NOT RELATED TO FITNESS TO DRIVE

***VIII. DOCTORS DETAILS** (PLEASE PRINT NAME AND ADRESS IN CAPITAL LETTERS)*

NAME:

ADDRESS:

TELEPHONE:

EMAIL ADRESS:

FAX NUMBER:

SIGNATURE AND STAMP OF MEDICAL PRACTITIONER:

DATE OF EXAMINATION:

IX. PATIENTS DETAILS
To be filled in the presence of the Medical Practitioner carrying out the examination
YOUR DETAILS

YOUR FULL NAME	
YOUR ADDRESS	
EMAIL ADDRESS	
DATE OF BIRTH	
HOME PHONE #	
WORK/DAYTIME #	

ABOUT YOUR GP/GROUP PRACTICE

GP/GROUP NAME	
ADDRESS	
EMAIL ADDRESS	
DATE OF BIRTH	
PHONE NUMBER	
FAX NUMBER	

X. PATIENTS CONSENT AND DECLARATION

Consent and Declaration

This section MUST be filled in and must NOT be altered in any way.

Please read the following important information carefully then sign to confirm the statements below.

Important information about Consent

On occasion, as part of the investigation into your fitness to drive, RTA may require you to undergo a medical examination or some form of practical assessment. In these circumstances, those personnel involved will require your background medical details to undertake an appropriate and adequate assessment. Such personnel might include doctors, orthoptists at eye clinics or paramedical staff at a driving assessment center. Only information relevant to the assessment of your fitness to drive will be released. In addition, where the circumstances of your case appear exceptional, the relevant medical information would need to be considered by one or more members of the DHA MEDICAL TEAM. The membership of these Panels conforms strictly to the principle of confidentiality.

CONSENT AND DECLARATION

I authorize my Doctor(s) and Specialist(s) to release reports/medical information about my condition relevant to my fitness to drive, to the RTA.

I authorize my Doctor(s) and Specialist(s) to release reports/medical information as may be necessary to the investigation of my fitness to drive, to Doctors, Paramedical staff and Panel members.

I declare that I have checked the details I have given on the enclosed questionnaire and that, to the best of my knowledge and belief, they are correct.

I understand that it is a criminal offence if I make a false declaration to obtain a driving license and can lead to prosecution

NAME:
SIGNATURE:
DATE: