DIABETES MEDICAL REPORT

P-142D REV. 4-2011

STATE OF CONNECTICUT
DEPARTMENT OF MOTOR VEHICLES
DRIVER SERVICES DIVISION
ct.gov/dmv

DRIVER'S LICENSE NUMBER

CDL/PS ☐ YES ☐ NO

MAIL TO: DMV, Driver Services Division, 60 State Street, Wethersfield, CT 06161-2510 Address incident of

The patient named below has been referred to the DMV Driver Services Division concerning their ability to safely operate a motor vehicle. This medical report must reflect the results of the medical professional's (licensed physician, PA or APRN) personal examination of the patient performed within 90 days of this report being filed. It must be signed by the patient authorizing the medical professional to release this report and any attachments to DMV.

I hereby authorize the medical professional completing and signing this medical report to release such report to DMV along with any other medical information necessary to determine my fitness to safely operate a motor vehicle.	**PATIENT'S SIGNATURE** X	**DATE**

PATIENT'S NAME *(Please Print)* *(Last)* *(First)* *(Initial)*	**DATE OF BIRTH**	**TELEPHONE NUMBER** ( )

PATIENT'S ADDRESS *(Street)* *(City)* *(State)* *(Zip Code)*

ONSET	**DATE:**		
	HOW LONG HAVE YOU BEEN TREATING THIS PATIENT?	**HOW OFTEN DO YOU SEE THIS PATIENT REGARDING DIABETES?**	**DATE OF LAST EXAMINATION:**
CURRENT THERAPY	**ORAL AGENT:** ☐ YES ☐ NO	**IF YES, KIND**	**DOSAGES:**
	INSULIN: ☐ YES ☐ NO	**IF YES, NUMBER OF YEARS/TYPE**	**DOSAGES:** **AM** **PM**
	NON-INSULIN INJECTABLE: ☐ YES ☐ NO	**IF YES, KIND**	**DOSAGES:**

ASSOCIATED CLINICAL PHENOMENA	**QUESTIONS:**	**YES**	**NO**	
	DOES SYMPTOMATIC HYPOGLYCEMIA OCCUR?	☐	☐	
	IS GLUCAGON USED OR NEEDED FOR MANAGEMENT?	☐	☐	
	IS CONSCIOUSNESS LOST OR ALTERED?	☐	☐	IF YES, ON WHAT DATE?
	IS THERE A LUCID PRODROME WITH HYPOGLYCEMIA?	☐	☐	
	DOES PATIENT MANAGE THE EVENT WITHOUT HELP?	☐	☐	
	DO YOU KNOW IF HYPOGLYCEMIA HAS CONTRIBUTED TO A MOTOR VEHICLE ACCIDENT?	☐	☐	IF YES, ON WHAT DATE?
	IS THERE SIGNIFICANT NEUROPATHY? SENSORIMOTOR	☐	☐	
	CRANIAL NERVE	☐	☐	
	AUTONOMIC	☐	☐	
	IS THERE SUFFICIENT RETINOPATHY TO ACCOUNT FOR VISION LOSS?	☐	☐	
	HAS AMPUTATION BEEN NECESSARY?	☐	☐	
DO YOU BELIEVE THIS PATIENT UNDERSTANDS THE RISK POSED BY HIS/HER CONDITION(S) WHICH MAY AFFECT HIS/HER ABILITY TO SAFELY OPERATE A MOTOR VEHICLE?		☐	☐	
DO YOU BELIEVE THIS PATIENT TAKES MEDICATION AS PRESCRIBED?		☐	☐	☐ **NOT APPLICABLE**
DO YOU HAVE REASON TO SUSPECT THIS PATIENT ABUSES ALCOHOL OR MEDICATIONS (INCLUDING ILLICIT DRUGS)?		☐	☐	

DMV MAY ISSUE A LICENSE SUBJECT TO PERIODIC STATUS REPORTS CONCERNING ANY CHANGES IN CONDITION(S). DOES THIS CONDITION WARRANT PERIODIC REPORTING?

☐ **YES** ☐ **NO** IF YES, PLEASE INDICATE THE CONDITION(S) AND RECOMMEND MONITORING INTERVAL(S):

CONDITION EVERY MONTHS FOR YEAR(S)

CONDITION EVERY MONTHS FOR YEAR(S)

☐ **YES** ☐ **NO** CONSIDERING THIS PATIENT'S CONDITION(S), DO YOU BELIEVE THIS PERSON MAY SAFELY OPERATE A MOTOR VEHICLE?

☐ **YES** ☐ **NO** CONSIDERING THIS PATIENT'S CONDITION(S), DO YOU BELIEVE THIS PERSON SHOULD BE ROAD TESTED AND/OR EVALUATED FOR SPECIAL EQUIPMENT REQUIREMENTS?

☐ **YES** ☐ **NO** ARE THERE ANY CONDITION(S) THAT SHOULD BE EVALUATED BY ANOTHER SPECIALIST? PLEASE EXPLAIN:

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

MEDICAL PROFESSIONAL'S NAME *(Please print or type)*	**OFFICE ADDRESS** *(Include Zip Code)*	
TELEPHONE NUMBER ( )	**MEDICAL PROFESSIONAL'S LICENSE NUMBER**	**MEDICAL PROFESSIONAL'S SPECIALTY**
MEDICAL PROFESSIONAL'S SIGNATURE X		**DATE REPORT COMPLETED**