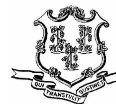
MEDICAL FORM
P-142M Rev. 2-20

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



☐ Department of Aging and Disability Services (ADS) / Driver Training Program (DTP) Referral

INSTRUCTIONS

- Patient: Complete section (A).
- Medical examiner(s) (licensed physician, PA or APRN): Complete section (B) and all subsections 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	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 a motor vehicle with special equipment? ☐ **YES** ☐ **NO**

This patient's medical condition indicates they are NOT safe to drive an unmodified vehicle PRIOR to completing the Driver Training Program through the Dept of Aging & Disability Services ☐

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:

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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.

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