DANGEROUS GOODS DRIVER LICENCE HEALTH ASSESSMENT FORM 2020/2021

ABOUT THIS FORM

If you wish to apply to WorkSafe ACT for the grant or renewal of an ACT dangerous goods driver licence, you must provide evidence that within the previous six months, you were assessed by a registered medical practitioner (**examining doctor**) against the current medical standards for commercial drivers and found to be fit to hold a commercial driver licence.

The examining doctor is responsible for determining whether you meet the criteria to be found fit to hold a commercial driver licence. This includes determining whether any new conditions should be placed on your road vehicle driver licence or any existing conditions amended, in light of this assessment.

If the examining doctor refers you to a specialist for further assessment, the examining doctor may need to consider the specialist's views before completing the Medical Certificate on page 2. The examining doctor should discuss this with you at the time of making the referral.

If your application for an ACT dangerous goods driver licence is successful, you may be required to undergo a further assessment during the licence period, either as a condition of the licence or by notice given under Section 207 of the *Dangerous Goods (Road Transport) Regulation 2010*.

Please note that WorkSafe ACT publishes a register of ACT dangerous goods driver licences, which includes any conditions placed on an individual licence. This includes conditions which may indicate that the licensee has a particular medical condition, such as a requirement for periodic review by a medical practitioner holding a particular speciality.

COMPLETING THIS FORM

Applicant (Patient)	Medical Practitioner
You must: • Complete the Patient Questionnaire section, **but do not sign until you are at the assessment.** • Take this form to the assessment, together with any required aids (e.g. spectacles, hearing aids etc). • Sign the Patient Questionnaire section **in front of the examining doctor.** • Show the examining doctor your current road vehicle driver licence including any licence conditions (even if the examining doctor is already familiar with you). • Provide any additional information which the examining doctor requests for the purpose of the assessment.	Your examining doctor must: • Read Part A and the relevant sections of Part B of the current edition of *Assessing Fitness to Drive* https://austroads.com.au/drivers-vehicles • Sight your current road vehicle driver licence including any licence conditions. • Review the Patient Questionnaire section with you and answer any questions you have about the questionnaire. • Complete the Clinical Examination section with the examination results, then sign and date. • Complete the Medical Certificate section with their findings and recommendations, then sign and date. • Keep a copy of this form on file as part of the records of your assessment and return the original to you.

SUBMITTING THIS FORM

This form may be submitted online as part of an application for the grant or renewal of an ACT dangerous goods driver licence, using the online application form at www.act.gov.au/dgdriverlicence.

If this form is being submitted to comply with a condition on an existing ACT dangerous goods driver licence or a notice under Section 207 of the *Dangerous Goods (Road Transport) Regulation 2010*, or in support of an application which has already been submitted to WorkSafe ACT, the form may be submitted by e-mail to DangerousSubstances@act.gov.au.

This form must be submitted in PDF format, with all sections being clear and legible.

If you are having difficulties in submitting this form online or by e-mail, please contact the Dangerous Substances Licensing unit of WorkSafe ACT on 13 22 81 for assistance.

MEDICAL CERTIFICATE (to be completed and signed by the examining doctor)

On _____ I carried out an assessment of fitness to drive for Mr/Ms _____ against the criteria set out in the medical standards for commercial drivers in the current edition of *Assessing Fitness to Drive* https://austroads.com.au/drivers-vehicles, being the *National Medical Standards for Licensing and Clinical Management Guidelines* (Commercial Standards).

During the assessment, I sighted this patient's current road vehicle driver licence including any existing licence conditions, and I have now obtained all of the information which I require in order to make a finding about their present fitness to drive, including all of the details required by the Patient Questionnaire on pages 3-4.

Findings – Commercial Driver Licence Criteria

☐ I find that this patient meets the criteria for an **unconditional** commercial driver licence.

☐ I find that this patient does not meet the criteria for an unconditional commercial driver licence but meets the criteria for a conditional commercial driver licence, **and I have made further findings about appropriate licence conditions** below.

☐ I find that this patient **does not meet the criteria** for a commercial driver licence.

Further Findings – Licence Conditions

☐ I find that **no further conditions** should apply to this patient other than those already shown on their road vehicle driver licence, including any requirement for periodic review by a general practitioner or specialist.

☐ I find that **the following further condition(s) should apply** to this patient in addition to any conditions already shown on their road vehicle driver licence, including any requirement for periodic review by a general practitioner or specialist:

_____

_____

_____

_____

_____

_____

I certify that the above information is true and correct, and that I have advised the patient that I may be required to provide the records of this assessment (and any other documents which I relied upon in making the above findings) to the Fitness to Drive Medical Clinic for review, upon request from the licensing authority.

Name:	
Date Signed: ……../……../……	Signature: _____
Name of Practice:	RUBBER STAMP DETAILS HERE
Address of Practice:	
Phone number:	
Fax number:	
E-mail:	

The examining doctor is expected to keep a copy of the completed form, including the completed and signed Patient Questionnaire and Clinical Examination sections, as part of the records of this assessment. The original form must be returned to the patient once the examining doctor has completed and signed the Medical Certificate section.

HEALTH ASSESSMENT REPORT (to be completed by the patient and signed in front of the examining doctor)

Please answer each question by ticking the correct box. If you are not sure how to answer a question, leave it unanswered until you attend the assessment and ask the examining doctor for assistance. The examining doctor should review your answers and may discuss these answers with you and/or ask you additional questions during the assessment.

Patient's Name:

Patient's Address:

1.	Are you currently being treated by a medical practitioner for any illness or injury?	☐ Yes	☐ No
2.	Are you receiving any medical treatment or taking any medication (either prescribed or otherwise)? *Please take medications with you to show the medical practitioner*	☐ Yes	☐ No
3.	Have you ever had, or been told by a medical practitioner that you had any of the following?	☐ Yes	☐ No
3.1	High blood pressure	☐ Yes	☐ No
3.2	Heart disease	☐ Yes	☐ No
3.3	Chest pain, Angina	☐ Yes	☐ No
3.4	Any condition requiring heart surgery	☐ Yes	☐ No
3.5	Palpitations/irregular heartbeat	☐ Yes	☐ No
3.6	Abnormal shortness of breath	☐ Yes	☐ No
3.7	Head injury, spinal injury	☐ Yes	☐ No
3.8	Seizures, fits, convulsions, epilepsy	☐ Yes	☐ No
3.9	Blackouts, fainting	☐ Yes	☐ No
3.10	Stroke	☐ Yes	☐ No
3.11	Dizziness, vertigo, problems with balance	☐ Yes	☐ No
3.12	Double vision, difficulty seeing	☐ Yes	☐ No
3.13	Colour blindness	☐ Yes	☐ No
3.14	Kidney disease	☐ Yes	☐ No
3.15	Diabetes	☐ Yes	☐ No
3.16	Neck, back or limb disorders	☐ Yes	☐ No
3.17	Hearing loss or deafness, had an ear operation, or use of a hearing aid	☐ Yes	☐ No
3.18	Do you have difficulty hearing people on the telephone (including if using a hearing aid)?	☐ Yes	☐ No
3.19	Have you ever had, or been told by a medical practitioner that you have had a psychiatric illness or nervous disorder?	☐ Yes	☐ No
3.20	Have you ever had any other serious injury, illness, operation or been in hospital for any reason?	☐ Yes	☐ No
4.1	Have you ever had, or been told by a medical practitioner that you have had a sleep disorder, sleep apnoea, or narcolepsy?	☐ Yes	☐ No
4.2	Has anyone noticed that your breathing stops or is disrupted by episodes of choking during sleep?	☐ Yes	☐ No
4.3	How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? **Use the following scale to choose the most appropriate number for each situation below:** **0 would never doze off** **1 slight chance of dozing** **2 moderate chance of dozing** **3 high chance of dozing** **It is important that you put a number (0 to 3) in each of the 8 boxes**		
4.3.1	Sitting and reading		
4.3.2	Watching TV		
4.3.3	Sitting, inactive in a public place (e.g a theatre or meeting)		
4.3.4	As a public passenger in a car for an hour without a break		
4.3.5	Lying down to rest in the afternoon when circumstances permit		
4.3.6	Sitting and talking to someone		
4.3.7	Sitting quietly after a lunch without alcohol		
4.3.8	In a car, while stopped for a few minutes in the traffic		

5.	**Please tick the answer that is correct for you:**
5.1	How often do you have a drink containing alcohol? ☐ Never ☐ Monthly ☐ 2 – 4 times a month ☐ 2 -4 times a week ☐ 4 or more times a week
5.2	How many drinks containing alcohol do you have on a typical day when you are drinking? ☐ 1 - 2 ☐ 3 - 5 ☐ 5 - 6 ☐ 7 - 9 ☐ 10 or more
5.3	How often do you have six or more drinks on one occasion? ☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily
5.4	How often during the last year have you found that you were not able to stop drinking once you had started? ☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily
5.5	How often during the last year have you failed to do what was normally expected from you because of drinking? ☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily
5.6	How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session? ☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily
5.7	How often during the last year have you had a feeling of guilt or remorse after drinking? ☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily
5.8	How often during the last year have you been unable to remember what happened the night before because you had been drinking? ☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily
5.9	Have you or someone else been injured as a result of your drinking? ☐ No ☐ Yes, but not in the last year ☐ Yes, during the last year
5.10	Has a relative, friend, doctor or other health worker been concerned about your drinking or suggest you cut down? ☐ No ☐ Yes, but not in the last year ☐ Yes, during the last year
6.	Do you use illicit drugs? ☐ Yes ☐ No
7.	Do you use any drugs or medications not prescribed by a medical practitioner ☐ Yes ☐ No
8.	Have you been a vehicle crash since your last licence examination ☐ Yes ☐ No

Patient's Declaration

I, _____ declare that the above information (and any other information which I have provided for the purpose of an assessment of my fitness to drive) is true and correct to the best of my knowledge and understanding. I acknowledge that giving false or misleading information is a serious offence under the *Criminal Code 2002*.

Signature: _____ Date Signed:

CLINICAL EXAMINATION (to be completed and signed by the examining doctor)

The examining doctor will be guided by findings in the Patient Questionnaire and any referral letter or other relevant information, and may apply appropriate tests other than those outlined here, in line with the *National Medical Standards for Licensing and Clinical Management Guidelines* (Commercial Standards) – for example, Mini Mental State or equivalent for cognitive conditions.

Patient's Name:

Patient's Address:

1. Cardiovascular System			
1.1	Blood pressure (repeat if necessary)		
	Systolic	mm Hg	mm Hg
	Diastolic	mm Hg	mm Hg
1.2	Pulse rate	☐ Regular	☐ Irregular
1.3	Heart Sounds	☐ Normal	☐ Abnormal
1.4	Peripheral pulses	☐ Normal	☐ Abnormal
2. Chest/Lungs		☐ Normal	☐ Abnormal
3. 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 movement	☐ Normal	☐ Abnormal
4.5	Reflexes	☐ Normal	☐ Abnormal
4.6	Romberg's signs (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 thirty seconds).	☐ Normal	☐ Abnormal
5. Vision			
5.1	Visual acuity	Uncorrected	Corrected
		R / L	R / L
	Are contact lenses worn? ☐ Yes ☐ No	6/ / 6/	6/ / 6/
5.2	Visual fields (confrontation to each eye)	☐ Normal	☐ Abnormal
6. 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. **Score**

Relevant Clinical Findings

Note comments on any relevant findings detected in the questionnaire or examination, making reference to the requirements of the current *National Medical Standards for Licensing and Clinical Management Guidelines* (Commercial Standards).

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature: _____ Date Signed: