TEXAS
Health and Human Services

Texas Department of State Health Services

Jennifer A. Shuford, MD, MPH
Commissioner

PLEASE USE THIS AS A COVER SHEET

PLEASE PROVIDE THIS LETTER WITH THE ATTACHED MEDICAL EVALUATION FORM TO BE COMPLETED BY YOUR PHYSICIAN

Dear Healthcare Provider:

The attached form has been brought to you by a candidate for, or current holder of, a Texas Driver's License. They have been referred by the Texas Department of Public Safety (DPS) to the Texas Department of State Health Services Medical Advisory Board **(DSHS MAB)** due to a concern about the candidate's medical history. The relevant section(s) pertaining to the candidate's referral MUST be **completely** filled out in order to process the referral.

If this is the first time you have seen this patient, please record what the patient states was their last occurrence of the reported medical issue. Additionally, please state this is the first time you have seen this patient, and this is the information that has been provided to you.

The Health and Safety Code authorizes the MAB to require the person to undergo a medical examination at his or her own expense. At this time, we are calling for a thorough and current medical evaluation, as it pertains to any medical limitations to driving. Current medical information is defined in Medical Advisory Board rules as being less than 12 months old. An examination will be necessary if one has not been conducted within 12 months. Please complete and return this MAB Medical History Form to the MAB at the following:

Email	Fax	Mail
dshsmab@dshs.texas.gov	**512-206-3778**	Texas Department of State Health Services ATTN: Medical Advisory Board (MC 1876) PO Box 149347 Austin, Texas 78714-9909

***For quickest response and processing times, we recommend emailing or faxing the completed paperwork.**

Health and Safety Code, Title 2 Subchapter H, Section 12.098, is the law pertaining to your liability protection, as it concerns any professional opinion, recommendation, or report you make for the purpose of assisting us in determining a candidate's ability to operate a motor vehicle.

Please note you are providing medical information and your professional medical opinion of this person's capability to drive.

If you have any questions about the forms or the procedure, please call (512) 834-6700 option 4.

Medical Advisory Board,
Texas Department of State Health Services.

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Medical Advisory Board (MAB) Medical Evaluation Form (Required)

The Texas Department of Public Safety (DPS) has requested that the Medical Advisory Board (MAB) assist them in the evaluation of the case of:

Patient Information:	
Name:	
Date of Birth:	
Driver's License or Case Number:	
Email:	
Phone number:	
Signature giving the Medical Advisory Board Permission to contact physician for additional information.	

because of a concern about the candidate's medical history as it pertains to his/her license to operate a motor vehicle. Authority to perform this review is in accordance with the Transportation Code, Chapter 521, Section 321, the Health and Safety Code, Chapter 12, Sections 091 - 098, and the implementing rules adopted by the Texas Department of State Health Services.

Health and Safety Code, Title 2 Subchapter H, Section 12.098,

Is the law pertaining to your liability protection, as it concerns any professional opinion, recommendation, or report you make for the purpose of assisting us in determining a candidate's ability to operate a motor vehicle. (Excerpt below, visit our website Medical Advisory Board | Texas DSHS for full statue.) Health and Safety Code, Title 2, Subtitle A, Chapter 12, Subchapter H, Medical Advisory Board - Sec. 12.098. Liability.

Physician Information (Required):		
Physician Name (Print)		
Physician Signature (MD/DO)		
Date		
Physician License #		**Specialty:**
Business Address		
Phone Number		
******Medical forms completed by APP must be co-signed by Supervising Physician******		
Advanced Practice Provider Name		
Advanced Practice Provider Signature		
Advanced Practice Provider License #		
Advanced Practice Provider Phone		

Please note you are providing medical information and your professional medical opinion of this person's capability to drive, as you are physically evaluating the individual. Please read below for legal liability concerns.

Health and Safety Code, Title 2 Subchapter H, Section 12.098, is the law pertaining to your liability protection, as it concerns any professional opinion, recommendation, or report you make for the purpose of assisting us in determining a candidate's ability to operate a motor vehicle. (Excerpt below, visit our website Medical Advisory Board | Texas DSHS for full statue.) Added by Acts 1995, 74th Leg., Ch. 165, Sec. 9, eff. Sept. 1, 1995.

Health and Safety Code, Title 2 Subchapter H, Section 12.098,

Is the law pertaining to your liability protection, as it concerns any professional opinion, recommendation, or report you make for the purpose of assisting us in determining a candidate's ability to operate a motor vehicle. (Excerpt below, visit our website Medical Advisory Board | Texas DSHS for full statue.) Health and Safety Code, Title 2, Subtitle A, Chapter 12, Subchapter H, Medical Advisory Board - Sec. 12.098. Liability.

Patient Medical History (Required)

(Sections B-K are relevant for specific diagnoses/conditions.)

A. GENERAL PATIENT INFORMATION

(Section is required: failure to complete will result in return of form)

1) **DATE OF EVALUATION:** _____

2) Condition(s) and diagnoses the patient is being treated for:

_____

Date of last episode: _____

3) List all current medications (include dose and frequency. If prn, average frequency of use)

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

4) When did you start providing care for this patient? Date: _____

5) Date the patient was last treated: _____

6) Treatment provided: _____

7) In your opinion, can the patient safely operate a motor vehicle? **Yes** ☐ **No** ☐

If no, please provide reason (mandatory) _____

8) Do you recommend a DPS driving evaluation? **Yes** ☐ **No** ☐

9) Supporting Information (REQUIRED – will NOT be reviewed if left blank)

Please provide any additional information or specific comments regarding the patient's medical evaluation and capability for driving (include treatment plan, notes about condition stability and treatment compliance, ER and hospital visits related to above conditions – include ED/MD notes). Please include any recommendations or assurances related to driving (or **attach recent visit or progress notes**):

Complete additional sections B-K which are relevant to your patient.

B. BREATHING RELATED CONDITIONS		**NOT APPLICABLE ☐**
1)	Does the patient have asthma?	Yes ☐ No ☐
2)	Does the patient have COPD?	Yes ☐ No ☐
3)	Dyspnea?	
	☐ No	
	☐ Yes, at rest	
	☐ **Yes, with exertion with O2 sat > 88% without supplemental O2**	
	☐ **Yes, with exertion with O2 sat> 88% with supplemental O2**	
	☐ **Yes, with exertion and O2 sat< 88% even with supplemental O2**	

C. DISORDERS OF SLEEP/ALERTNESS		**NOT APPLICABLE ☐**
1)	Does the patient have sleep apnea?	Yes ☐ No ☐
	If Yes (required)	
	What was the AHI (Apnea-Hypopnea Index) prior to treatment?	
	What is the AHI (Apnea-Hypopnea Index) score on treatment?	
	Is the patient compliant with treatment?	Yes ☐ No ☐
2)	Does the patient have narcolepsy?	Yes ☐ No ☐
	If Yes	
	Is the patient compliant on medication?	Yes ☐ No ☐
	Does the patient have uncontrolled daytime sleepiness or sleep attacks?	Yes ☐ No ☐
	If Yes, What is the frequency of the attacks and what was the date of the last attack? Frequency: _____ Date: _____	

D. VASCULAR DISEASE *(To be completed by cardiology)*		**NOT APPLICABLE ☐**
1)	Cardiovascular Disease/Heart Failure-Functional Classification American Heart Association (AHA) ☐ AHA Class I — AHA Class I: No symptoms ☐ AHA Class II — AHA Class II: Symptoms with strenuous activity ☐ AHA Class III — AHA Class III: Symptoms with normal activity ☐ AHA Class IV — Class IV: Symptoms at rest	
2)	**Cardiovascular Disease/Heart Failure – Objective medical classification:** ☐ Class A - No objective evidence of cardiovascular disease ☐ Class B - Objective evidence of minimal cardiovascular disease ☐ Class C - Objective evidence of moderately severe cardiovascular disease ☐ Class D - Objective evidence of severe cardiovascular disease	

D. VASCULAR DISEASE CONTINUED…

3) Blood pressure: _____ Heart Rate: _____

4) **Angina Pectoralis:**

☐ At rest or with minimal exertion
☐ With mild exertion (walking 1-2 blocks, climbing 1 flight of stairs)
☐ With moderate exertion
☐ With severe exertion

5) **Malignant hypertension or hypertensive urgency:** Yes ☐ No ☐

6) **Coronary Artery Disease/Myocardial Infarction/D.V.T.**

1) Yes ☐ No ☐ Myocardial Infarction Date: _____
2) Yes ☐ No ☐ DVT Date: _____
3) Yes ☐ No ☐ Bypass grafting Date: _____
4) Yes ☐ No ☐ Stenting Date: _____

5) **Cleared to drive?**
By PCP? **Yes ☐ No ☐** (for drivers with Private Owner driver license)

By Cardiology? **Yes ☐ No ☐ (REQUIRED for drivers with Commercial driver license)**

6) **Stable?** On antiplatelet agents **Yes ☐ No ☐**
On anticoagulants **Yes ☐ No ☐**

7)	**Arrythmias:**	
	a) Syncopal episode(s) associated with cardiac condition If Yes, Date: _____	Yes ☐ No ☐
	b) Atrial fibrillation/flutter	Yes ☐ No ☐
	Undertreatment by cardiology	Yes ☐ No ☐
	Heart Rate is controlled	Yes ☐ No ☐
	On stable anticoagulation	Yes ☐ No ☐
	c) Av nodal re-entry tachycardia	**Yes ☐ No ☐**
	Symptomatic	Yes ☐ No ☐
	Not symptomatic OR controlled with catheter ablation or medial therapy	Yes ☐ No ☐
	d) Wolff Parkinson White syndrome	**Yes ☐ No ☐**
	With atrial fibrillation	Yes ☐ No ☐
	Without atrial fibrillation	Yes ☐ No ☐
	e) Ventricular tachycardia	**Yes ☐ No ☐**
	History of sustained V tach	Yes ☐ No ☐
	Non-sustained V tach	Yes ☐ No ☐
	Controlled with medication	Yes ☐ No ☐
	Date of tachycardia control	

Continued on page 7

D. VASCULAR DISEASE CONTINUED…		
	f) Other Arrythmias Specific type:	
	g) Has Pacemaker been placed? Has AICD (defibrillator) been placed? Date of Placement: _____	Yes ☐ No ☐ Yes ☐ No ☐
8)	**Heart block- if applicable Check one** ☐ First Degree ☐ Second degree Mobitz I ☐ Second degree Mobitz II ☐ Third degree	
9)	**Commercial Drivers Only:** Has the patient completed Stage II of the standard Bruce protocol (treadmill test) within the last year? **(Required: ATTACH TEST RESULTS)**	**Yes ☐ No ☐**

E. BLACKOUT **NOT APPLICABLE ☐** *(UNEXPLAINED temporary loss of consciousness with no recall) OR, SYNCOPE (fainting)*	
a) Single episode?	Yes ☐ No ☐
b) Multiple episodes?	Yes ☐ No ☐
If multiple, how many episodes in the last year?	
c) Date of episode (if single) or most recent episode	
d) Cause of syncope:	
e) Vasovagal (cause of vagal episode if known)	
f) Neurocardiogenic	Yes ☐ No ☐
g) Hypotensive (cause of hypotension if known)	
h) Arrhythmia (complete relevant vascular section)	Yes ☐ No ☐
i) Other (cause if known)	
j) Unknown - provide documentation of any evaluation: (general, cardiac, neuro)	
k) In your opinion, is the condition controlled?	Yes ☐ No☐

F. NEUROLOGICAL **NOT APPLICABLE ☐**		
1)	**TIA**	
	Single episode?	Yes ☐ No ☐
	Multiple episodes?	Yes ☐ No ☐
	If multiple, how many TIAs in the last year?	
	Date of most recent TIA:	
	Stable on antiplatelet or anticoagulant therapy?	Yes ☐ No ☐

Continued on page 8

F. NEUROLOGICAL CONTINUED…		
2)	**CVA/Stroke**	
	a) Residual Deficits ☐ None ☐ Mild ☐ Moderate ☐ Severe	Yes ☐ No ☐
	b) If moderate to severe, describe deficit(s):	
	c) Treatment and compliance:	
	d) Any visual deficits? (If yes, complete visual evaluation section **K** below)	Yes ☐ No ☐
	e) Any language deficits If yes, describe:	Yes ☐ No ☐
3)	**Seizures**	
	a) Date of last seizure:	
	b) Number of seizures in the last year:	
	c) On anticonvulsants?	Yes ☐ No ☐
	d) The patient reliably takes his/her anticonvulsant?	Yes ☐ No ☐
	e) Does the patient experience daytime somnolence with medication?	Yes ☐ No ☐
	f) Any other medication side effects which might interfere with driving? If yes, what side effects?	Yes ☐ No ☐
	g) Does the patient consume excess alcohol?	Yes ☐ No ☐
4)	**Cognitive impairment/Dementia**	
	a) MMSE or MoCA score (in the last 3 months-required) Score:	
	b) Has the patient had an O.T. evaluation for driver safety? If yes, supply the report	Yes ☐ No ☐
	c) Has the patient had neuropsychological testing in the last year? **If yes, supply the report**	Yes ☐ No ☐
5)	**Vertigo/Dizziness** Severity (Check one): ☐ Minimal (intermittent or chronic mild) ☐ Mild (acute episodic vertigo, stable on medication) ☐ Moderate (Benign positional vertigo, acute/chronic vestibulopathy) ☐ Severe (Meniere's Disease, nonfunctioning labyrinths)	
6)	**Other miscellaneous neurologic disorders (traumatic brain injury, movement disorders such as Parkinson's, Multiple Sclerosis, peripheral neuropathy**	
	a) Diagnosis:	
	b) Severity (Check one): ☐ Mild ☐ Moderate ☐ Severe	
	If the condition is associated with cognitive impairment, complete Section F (4) above	

G. PSYCHIATRIC		**NOT APPLICABLE ☐**
a)	**Diagnosis:**	
b)	**At the time of this evaluation, is the patient:**	
	Aggressive, assaultive, or excessively hostile?	Yes ☐ No ☐
	Experiencing hallucinations or delusions?	Yes ☐ No ☐
	Homicidal?	Yes ☐ No ☐
	Suicidal?	Yes ☐ No ☐
	Impulsive?	Yes ☐ No ☐
	Paranoid?	Yes ☐ No ☐
	Exhibiting impaired judgement?	Yes ☐ No ☐
c)	Is the patient compliant with medication/ treatment?	Yes ☐ No ☐
d)	Do medications cause any drowsiness or adverse effects that would impair driving?	Yes ☐ No ☐
e)	**In your opinion, is the psychiatric condition adequately controlled?**	Yes ☐ No ☐

H. ALCOHOL AND DRUG USE/ABUSE		**NOT APPLICABLE ☐**
a)	Substance used or abused:	
b)	Length of use/dependency:	
c)	Last known use:	
d)	Number of times treated:	
e)	Month/year of last treatment:	
f)	Member of AA/NA:	Yes ☐ No ☐ **(ATTATCH SUPPORTING DOCUMENTS/CERTIFICATES)**
g)	On Methadone/Antabuse:	Yes ☐ No ☐
h)	Urine drug screen ***(required for history of drug use)*** **ATTACH RESULTS**	**Yes ☐ No ☐**
i)	**Urine for ethyl glucuronide/ethyl sulfate** ***(required for history of alcohol abuse)*** **ATTACH RESULTS**	**Yes ☐ No ☐**

I. METABOLIC DISEASE		**NOT APPLICABLE ☐**
a)	**Chronic severe or end stage renal failure**	**Yes ☐ No ☐**
	If yes, compliant with medical therapy/dialysis?	
b)	**Diabetes**	**Yes ☐ No ☐**
	On oral agents	Yes ☐ No ☐
	On insulin	Yes ☐ No ☐
	HgbA1c:	
c)	Any episodes of DKA, coma, shock, or symptomatic hypoglycemia	Yes ☐ No ☐
d)	Number of incidents in the last year:	

Continued on page 10

I. METABOLIC DISEASE CONTINUED…		
e)	Any incidents require hospitalization	Yes ☐ No ☐
f)	Is the patient compliant with therapy?	Yes ☐ No ☐
g)	Does the patient have a Continuous Glucose Monitor (CGM)	Yes ☐ No ☐
h)	Does the patient have any issues with neuropathy due to diabetes?	Yes ☐ No ☐
i)	Does the patient have any visual deficits due to the diabetes? If Yes, (complete visual evaluation section **K** below)	Yes ☐ No ☐

J. MUSCULOSKELETAL		**NOT APPLICABLE ☐**
a)	Any functional impairment of upper or lower extremities (arthritis, weakness, spasticity)?	Yes ☐ No ☐
	If yes, specify condition and describe impairment:	
b)	Is the condition progressive?	Yes ☐ No ☐
c)	Is assistive equipment employed?	Yes ☐ No ☐
d)	**If so, is the equipment effective in allaying functional impairment?**	**Yes ☐ No ☐**

K. VISION *(Must be completed by ophthalmology or optometry)*				**NOT APPLICABLE ☐**
a)	**Cause of visual impairment:**			
b)	**Visual acuity:**			
	Without correction:	R 20/	L 20/	
	With present correction:	R 20/	L 20/	
	With best correction:	R 20/	L 20/	
c)	Does the patient use a biopic telescope?			Yes ☐ No ☐
	If yes,			
	Type of biopic telescope?			
	Power of telescope?			
	Visual acuity with telescope	R 20/	L 20/	
d)	Does the patient have diplopia?			Yes ☐ No ☐
	If yes, is the diplopia constant?			Yes ☐ No ☐
e)	Is the diplopia monocular?			Yes ☐ No ☐
	If yes, which eye?			
f)	Is the diplopia correctable with a patch?			Yes ☐ No ☐
g)	Does the patient have a visual field impairment?			Yes ☐ No ☐
	If yes, describe type and degree of field loss (ATTACH visual field test results):			