DL-124 (12-12)

GENERAL NEUROLOGICAL FORM

PLEASE TYPE OR PRINT IN BLUE OR BLACK INK ALL INFORMATION

pennsylvania
DEPARTMENT OF TRANSPORTATION

Bureau of Driver Licensing
P.O. Box 68682
Harrisburg, PA 17106-8682
(717) 787-9662

THIS FORM APPROVED BY THE MEDICAL ADVISORY BOARD 11/16/2012
Provider: For more information relating to Medical Reporting, visit http://www.dmv.state.pa.us/centers/medicalReportingCenter.shtml.

PATIENT INFORMATION (Please complete this form in its entirety)

DRIVER'S LICENSE NO.	LAST NAME(S)	JR. ETC	FIRST NAME

HEIGHT FEET	HEIGHT INCHES	SEX	EYE COLOR	DATE OF BIRTH MONTH	DAY	YEAR	TELEPHONE NUMBER	E-MAIL (if applicable)

STREET ADDRESS: P.O. Box number may be used in addition to the actual address, but cannot be used as the only address.	CITY	STATE	ZIP CODE

1. How long have you been treating the patient?_____
2. Has the patient been diagnosed with a neurologic disorder? _____
3. Has the patient had a loss of consciousness due to cerebral vascular insufficiency? _____

   If yes, date of last episode:_____
4. Does the patient have impairment in any of the following areas which would make him/her unsafe to drive?

   a. Reaction time? _____

   b. Coordination of movement of the extremities? _____

   c. Muscular strength?_____
5. Does the patient have any paralysis? _____ If yes, please explain: _____
6. Does the patient have excessive aggressiveness or disregard for the safety of self or others or both that would make him/her unsafe to drive? _____
7. Does the patient have any cognitive impairment(s) which would make him/her unsafe to drive, including but not limited to attentiveness to the task of driving, judgement and problem solving, planning and sequencing, visuospatial perception and or memory? _____
8. Has the patient had a loss of visual fields?_____ If yes, please explain: _____
9. Is the patient being treated with medicine? _____ If yes, please specify: _____

   _____

   Does the medication(s) make him/her an unsafe driver?. . . . . ❑ YES ❑ NO

HEALTH CARE PROVIDER INFORMATION (Please print or type)

HEALTH CARE PROVIDER'S NAME	SPECIALTY	HEALTH CARE PROVIDER'S LICENSE NUMBER	
STREET ADDRESS	CITY	STATE	ZIP CODE
TELEPHONE NUMBER	FAX NUMBER		

I hereby state that the facts above set forth are true and correct to the best of my knowledge, information and belief. I understand that the statements made herein are made subject to the penalties of 18 Pa. C.S. § 4904 (relating to unsworn falsification to authorities) punishable by a fine up to $2,500 and/or imprisonment up to 1 year.

_____ _____

Health Care Provider's Signature | Date