

SEIZURE REPORTING 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		SEX	EYE COLOR	DATE OF BIRTH			TELEPHONE NUMBER	E-MAIL (if applicable)
FEET	INCHES			MONTH	DAY	YEAR		
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. Did the patient have a seizure? _____

If yes, date of the seizure: _____

3. Has the patient had more than one seizure? _____

4. Does the patient have an electrically diagnosed seizure disorder? _____

5. Has the patient had an EEG? _____ If yes, date of EEG: _____

6. Is the patient being treated with medication? _____ If yes, type and dosage: _____

Does the medication affect the patient's ability to safely operate a motor vehicle? _____

7. Other than a seizure disorder, does the patient have episode(s) of loss of consciousness or awareness

that would interfere with the safe operation of a motor vehicle? _____

If yes, please explain: _____

8. Does the patient have seizure(s) attributable to a **prescribed** change in or removal from medication? _____

If yes, when was the medication changed/discontinued? _____

If yes, date of last seizure: _____

Has the original medication been reintroduced? _____

PATIENT NAME _____

DRIVER'S LICENSE NUMBER _____

9. Does the patient have seizure(s) always preceded by a specific prolonged aura? _____

If yes, what is the duration of the aura? _____

How is it manifested? _____

Has the patient experienced the aura for at least 2 years? _____

10. Does the patient experience only an aura? _____

How is it manifested? _____

Has the patient experienced only an aura for at least 2 years? _____

11. Does the patient have a pattern of seizure(s) occurring only during sleep or immediately

upon awakening? _____ Has the patient experienced this pattern for at least 2 years? _____

12. Were the only seizure(s) the patient had within the last 6 months attributable to a nonrecurring transient

illness, toxic ingestion, or metabolic imbalance? _____

If yes, please explain and include dates of seizure(s): _____

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		
<p>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.</p>					
_____				_____	
Health Care Provider's Signature				Date	