NEUROLOGY MEDICAL REPORT
P-142N REV. 8-17

STATE OF CONNECTICUT
DEPARTMENT OF MOTOR VEHICLES
DRIVER SERVICES DIVISION
ct.gov/dmv

DRIVER'S LICENSE NUMBER

CDL/PS ☐ YES ☐ NO

MAIL TO: DMV, Driver Services Division, 60 State Street, Wethersfield, CT 06161-1013

The patient named below has been referred to the DMV Driver Services Division concerning their ability to operate a motor vehicle safely. This medical report must reflect the results of the licensed physician's personal examination of the patient performed within 90 days of this report being filed. It must be signed by the patient authorizing the physician to release this report and any attachments to DMV.

Address incident of

I hereby authorize the licensed physician completing and signing this medical report to release such report to DMV along with any other medical information necessary to determine my fitness to operate a motor vehicle safely.

PATIENT'S SIGNATURE X

DATE

PATIENT'S NAME *(Please Print)* *(Last)* *(First)* *(Initial)*

DATE OF BIRTH

TELEPHONE NUMBER ( )

PATIENT'S ADDRESS *(Street)* *(City)* *(State)* *(Zip Code)*

HOW LONG HAVE YOU BEEN TREATING THIS PATIENT?

DATE OF LAST EXAMINATION

HOW MANY YEARS HAS THIS PATIENT HAD THE CONDITION(S) YOU ARE TREATING? PLEASE PROVIDE A BRIEF DIAGNOSIS, ETIOLOGY, AND PROGNOSIS, INCLUDING DATES AND RESULTS OF EEG SCANS, AND/OR OTHER TEST RESULTS, AS NEEDED.

ARE THERE OTHER CONDITION(S) THAT SHOULD BE EVALUATED BY ANOTHER SPECIALIST? PLEASE EXPLAIN:

HISTORY OF EPISODES OF ALTERED CONSCIOUSNESS IN THE PAST TWO YEARS

DATE	TYPE	DATE	TYPE	DATE	TYPE
1.		3.		5.	
2.		4.		6.	

MEDICATIONS (RELEVANT TO MOTOR VEHICLE OPERATION)

DATE OF LAB WORK	TYPE/DOSE	BLOOD LEVEL	DATE OF LAB WORK	TYPE/DOSE	BLOOD LEVEL
1.			3.		
2.			4.		

DMV MAY ISSUE A LICENSE SUBJECT TO PERIODIC STATUS REPORTS CONCERNING ANY CHANGES IN CONDITION(S). DOES THIS CONDITION WARRANT PERIODIC REPORTING? ☐ **YES** ☐ **NO** IF YES, PLEASE INDICATE THE CONDITION(S) AND RECOMMEND MONITORING INTERVAL(S):

CONDITION EVERY MONTHS FOR YEAR(S)

CONDITION EVERY MONTHS FOR YEAR(S)

DO YOU BELIEVE THIS PATIENT UNDERSTANDS THE RISK POSED BY HIS/HER CONDITION(S) WHICH MAY AFFECT HIS/HER ABILITY TO SAFELY OPERATE A MOTOR VEHICLE? ☐ **YES** ☐ **NO**

DO YOU BELIEVE THIS PATIENT TAKES MEDICATION AS PRESCRIBED? ☐ **YES** ☐ **NO** ☐ **NOT APPLICABLE**

DO YOU HAVE REASON TO SUSPECT THIS PATIENT ABUSES ALCOHOL OR MEDICATIONS (INCLUDING ILLICIT DRUGS)? ☐ **YES** ☐ **NO**

ARE YOU AWARE OF ANY OTHER RELEVANT MEDICAL OR SURGICAL HISTORY? PLEASE EXPLAIN:

CONSIDERING THIS PATIENT'S CONDITION(S), DO YOU BELIEVE THIS PERSON MAY SAFELY OPERATE A MOTOR VEHICLE? ☐ **YES** ☐ **NO**

PHYSICIAN'S CERTIFICATION: I certify that I have personally examined the above named person within the 90 days preceding completion of this report. I swear or affirm under penalty of false statement in accordance with Connecticut General Statutes §14-110 and §53a-157b, and subject to penalties for perjury for a deliberate false statement, that the above information and any attachment hereto is true and correct.

PHYSICIAN'S NAME *(Please print or type)*

OFFICE ADDRESS *(Include Zip Code)*

TELEPHONE NUMBER ( )

PHYSICIAN'S LICENSE NUMBER

PHYSICIAN'S SPECIALTY

PHYSICIAN'S SIGNATURE X

DATE REPORT COMPLETED