



DEPARTMENT OF TRANSPORTATION  
DRIVER AND MOTOR VEHICLE SERVICES  
1905 LANA AVE NE, SALEM OREGON 97314

# MANDATORY IMPAIRMENT REFERRAL

(OAR CHAPTER 735 DIVISION 74)

THE MEDICAL INFORMATION IN THIS REPORT IS CONFIDENTIAL AND WILL BE USED BY THE DRIVER AND MOTOR VEHICLE SERVICES (DMV) ONLY TO DETERMINE THE QUALIFICATIONS OF THE PERSON TO OPERATE MOTOR VEHICLES.

LAST NAME (PLEASE PRINT) <b>Publique</b>	FIRST NAME <b>John</b>	MIDDLE NAME <b>Q.</b>	SEX <b>M</b>	ODL / CUSTOMER NUMBER <b>000000</b>	DATE OF BIRTH <b>01-01-40</b>
RESIDENCE ADDRESS <b>15 Anyplace NW</b>		CITY <b>Anywhere</b>	STATE <b>OR</b>	ZIP CODE <b>99999</b>	COUNTY <b>Coos</b>

The underlying medical condition or diagnosis is: Dementia

IMPAIRMENT(S) IS:  CHRONIC  PROGRESSIVE DATE OF MOST RECENT EXAM: 8-01-14

The patient named above is over 14 years of age and has the impairment(s) checked or described below. The impairment(s) is documented as **severe and uncontrollable** and not correctable by medication, therapy and/or surgery, driving device and/or techniques. Submission of this form may result in an immediate suspension of the patient's driving privileges.

Checking one or more of the boxes below indicates that the above referenced patient has one or more severe and uncontrollable functional and/or cognitive impairments listed on the reverse side unless otherwise described below.

**FUNCTIONAL IMPAIRMENTS:** (Check all that apply.)

- VISUAL ACUITY and/or FIELD OF VISION  
Patient is unable to meet the state vision standards listed below, even with correction:
  - Acuity must be no worse than 20/70 in the best eye
  - Horizontal field of vision of 110 degrees or greater (includes temporal and nasal vision of persons with usable vision in only one eye)
- STRENGTH
- PERIPHERAL SENSATION
- FLEXIBILITY
- MOTOR PLANNING & COORDINATION
- OTHER (describe): \_\_\_\_\_

**COGNITIVE IMPAIRMENTS:** (Check all that apply.)

- ATTENTION
- JUDGMENT & PROBLEM SOLVING
- REACTION TIME
- PLANNING & SEQUENCING
- IMPULSIVITY
- VISUOSPATIAL
- MEMORY
- OTHER: \_\_\_\_\_
- LOSS OF CONSCIOUSNESS OR CONTROL
  - Single recent episode:
  - Multiple recent episodes:
    - Date of Last Episode: \_\_\_\_\_
    - Medication to prevent recurrence: \_\_\_\_\_

Describe how the patient is affected by the impairment(s) checked above. Please provide any information relevant to the patient's ability to safely operate a motor vehicle. Relevant information includes but is not limited to: chart notes; pertinent test results; prescription or OTC medications that may interfere with safe driving behaviors; problem drug, alcohol, or inhalant use; or other factors that may contribute to the impairment.

- Progressive Loss of short-term memory ; SLUMS 12/30  
- Hit a parked car and does not recall crash / Is no longer safe to drive  
- Getting lost while driving  
- Unable to problem solve  
- Is easily disoriented  
- Continues to drive, although I have advised him he should not drive anymore

Are you the patient's primary care provider (PCP)?  YES  NO\*  
\* If "NO," does the patient have a PCP?  YES  NO

HEALTH CARE PROVIDER'S NAME (PLEASE PRINT) <b>Jane Doe, M.D.</b>	SPECIALTY <b>Family Practice</b>	LICENSE or CERTIFICATE # <b>MD000000</b>
MAILING ADDRESS <b>228 NW Anywhere Drive</b>	FAX # <b>(xxx)xxx-xxxx</b>	TELEPHONE # (and EXT.) <b>(xxx)xxx-xxxx</b>
CITY <b>Anywhere</b>	STATE <b>OR</b>	ZIP CODE <b>99999</b>
SIGNATURE OF HEALTH CARE PROVIDER <b>X Jane Doe, M.D.</b>		COUNTY <b>Coos</b>
		DATE SIGNED <b>8-01-14</b>