

Medical Examination Report

Concerning a Person's Fitness to Drive a Motor Vehicle

Driver Fitness

Box 6300
Winnipeg MB R3C 4A4
Tel: 204-985-1900 Fax: 204-953-4992 Toll Free: 1-866-617-6676



**MANITOBA
PUBLIC INSURANCE**

REASON FOR REPORT (SEE "X")	<input type="checkbox"/> APPLICANT FOR CLASS _____	<input type="checkbox"/> MEDICAL QUESTIONNAIRE
	<input type="checkbox"/> CLASS LICENCE RECALL	<input type="checkbox"/> SUSPENSION
	<input type="checkbox"/> REGISTRAR RECALL	<input type="checkbox"/> MEDICAL REVIEW COMMITTEE
	<input type="checkbox"/> REGISTRAR REQUIREMENT	<input type="checkbox"/> OTHER _____

MPI/Agent Use Only
Driver's Licence Number _____

DATE OF BIRTH _____	CLASS _____	RESTRICTION _____	THIS REPORT IS TO BE COMPLETED AND RETURNED TO DRIVER FITNESS
	STAGE _____		
BY: _____			

Medical Code	Auth	Frequency	Highest Class	Medical Action

HEALTH HISTORY AND PHYSICAL EXAMINATION

PLEASE ✓ AND COMPLETE RELEVANT INFORMATION

A CARDIO/CEREBRO/VASCULAR DISEASE * (Complete Sec. N-1)	6 <input type="checkbox"/> POOR CO-ORDINATION
1 <input type="checkbox"/> NO APPRECIABLE DISEASE	7 <input type="checkbox"/> MUSCLE WEAKNESS
2 <input type="checkbox"/> HYPERTENSION (Complete Sec. L)	8 <input type="checkbox"/> MULTIPLE SCLEROSIS
3 <input type="checkbox"/> ANGINA PECTORIS *	9 <input type="checkbox"/> DECREASED COGNITIVE FUNCTION
4 <input type="checkbox"/> CORONARY ARTERY DISEASE *	10 <input type="checkbox"/> DEMENTIA
5 <input type="checkbox"/> MYOCARDIAL INFARCTION *	11 <input type="checkbox"/> OTHER (COMMENT)
6 <input type="checkbox"/> CARDIAC ARRHYTHMIA *	E PSYCHIATRIC DISEASE
7 <input type="checkbox"/> VALVULAR HEART DISEASE *	1 <input type="checkbox"/> NO APPRECIABLE DISEASE
8 <input type="checkbox"/> CORONARY BYPASS SURGERY *	2 <input type="checkbox"/> DEPRESSION (Complete Sec. N-6)
9 <input type="checkbox"/> VALVE REPLACEMENT *	3 <input type="checkbox"/> OTHER
10 <input type="checkbox"/> CARDIAC PACEMAKER *	F RENAL DISEASE
11 <input type="checkbox"/> C V ACCIDENT	1 <input type="checkbox"/> NO APPRECIABLE DISEASE
12 <input type="checkbox"/> TRANSIENT ISCHEMIC ATTACKS	2 <input type="checkbox"/> RENAL FAILURE
13 <input type="checkbox"/> PERIPHERAL VASCULAR DISEASE	3 <input type="checkbox"/> RENAL DIALYSIS
14 <input type="checkbox"/> OTHER (COMMENT) *	4 <input type="checkbox"/> OTHER (COMMENT)
B METABOLIC-ENDOCRINE DISEASE	G RESPIRATORY DISEASE
1 <input type="checkbox"/> NO APPRECIABLE DISEASE	1 <input type="checkbox"/> NO APPRECIABLE DISEASE
2 <input type="checkbox"/> DIABETES MELLITUS (Complete Sec. N-2)	2 <input type="checkbox"/> C.O.P.D. (Complete Sec. N-5)
3 <input type="checkbox"/> OTHER (COMMENT)	3 <input type="checkbox"/> OTHER (COMMENT)
C MUSCULOSKELETAL DISEASE	I DISEASES OF THE SENSES
1 <input type="checkbox"/> NO APPRECIABLE DISEASE	1 <input type="checkbox"/> NO APPRECIABLE DISEASE
2 <input type="checkbox"/> LOSS - ALL OR PART OF A LIMB	2 <input type="checkbox"/> VISUAL FIELD DEFECT
3 <input type="checkbox"/> PAIN/DECREASED MOVEMENT LIMB/SPINE	3 <input type="checkbox"/> OCULAR DISEASE
4 <input type="checkbox"/> MUSCLE WEAKNESS LIMB/SPINE	4 <input type="checkbox"/> HEARING LOSS: L. EAR <input type="checkbox"/> R. EAR <input type="checkbox"/>
5 <input type="checkbox"/> OTHER (COMMENT)	5 <input type="checkbox"/> VERTIGO
D NERVOUS SYSTEM DISEASE	6 <input type="checkbox"/> OTHER (COMMENT)
1 <input type="checkbox"/> NO APPRECIABLE DISEASE	J OTHER CONDITIONS
2 <input type="checkbox"/> FAINTING SPELLS/BLACKOUTS	1 <input type="checkbox"/> NONE
3 <input type="checkbox"/> EPILEPSY/SEIZURES (Complete Sec. N-3)	2 <input type="checkbox"/> ALCOHOL USE DISORDER } (See N-4)
4 <input type="checkbox"/> NARCOLEPSY	3 <input type="checkbox"/> SUBSTANCE USE DISORDER }
5 <input type="checkbox"/> OBSTRUCTIVE SLEEP APNEA (Complete Sec. N-7)	4 <input type="checkbox"/> AFFECTED BY RX DRUG
	5 <input type="checkbox"/> PHYSIOLOGIC CHANGES OF AGING-PHYSICAL OR MENTAL
	6 <input type="checkbox"/> OTHER (COMMENT)

N# 1. IF CARDIAC: a) NYHA LEVEL 1 2 3 4
b) MI: ST elevation MI Non ST elevation MI
c) LV damage: significant minor
d) Ejection fraction: _____%

2. **DIABETES:** TYPE 1 TYPE 2 ONSET OF ILLNESS _____
DATE OF LAST SEVERE HYPOGLYCEMIC EPISODE _____

3. **EPILEPSY/Seizures:** Seizures Onset _____
DATE OF LAST SEIZURE _____ SYMPTOMS _____ NOCTURNAL? _____

4. **ALCOHOL/SUBSTANCE USE DISORDER:** MILD MODERATE SEVERE
IN REMISSION? EARLY SUSTAINED DATE ACHIEVED REMISSION _____
REHABILITATION PROGRAM COMPLETED? DESCRIBE _____

5. **RESPIRATORY IMPAIRMENT:** MILD MODERATE SEVERE
CONTINUOUS O₂ USE? YES NO

6. **DEPRESSION:** a) MILD SITUATIONAL CHRONIC MAJOR b) STABLE UNSTABLE

7. **OBSTRUCTIVE SLEEP APNEA:** OSA: Treated YES NO
Daytime Sleepiness YES NO AHI _____ Attach Sleep Studies

O DOES THIS DRIVER HAVE A COGNITIVE DEFICIT? YES NO
IF YES OR UNCERTAIN, DESCRIBE BELOW _____

P PLEASE DESCRIBE IN DETAIL INFORMATION IDENTIFIED IN A-O.

1. _____

2. ATTACH RELEVANT TEST RESULTS (EKG, EEG, IMAGING, ETC)

Q 1. HOW LONG HAS THIS PATIENT BEEN UNDER YOUR CARE? _____

2. DO YOU RECOMMEND ANY DRIVING RESTRICTIONS? YES NO
PLEASE SPECIFY _____

3. DO YOU RECOMMEND REMOVING THE LICENCE? YES NO

4. DO YOU RECOMMEND A SPECIALIST'S OPINION IN SUPPORT OF A DRIVER'S LICENCE? YES NO
SPECIALTY OF _____

5. HIGHEST CLASS OF LICENCE RECOMMENDED. _____

PHYSICIAN'S SIGNATURE _____ PHYSICIAN'S NAME (PRINTED) _____

DATE OF EXAMINATION _____ PHYSICIAN'S TELEPHONE NO. _____

I AUTHORIZE MY PHYSICIAN TO RELEASE THIS INFORMATION TO MANITOBA PUBLIC INSURANCE AND DRIVER ASSESSMENT AND MANAGEMENT PROGRAM.

DATE _____ SIGNATURE _____ TELEPHONE NO. _____

I AUTHORIZE MANITOBA PUBLIC INSURANCE TO RELEASE DRIVER TEST RESULTS TO MY PHYSICIAN.

DATE _____ SIGNATURE _____ TELEPHONE NO. _____

MPI USE ONLY MEDICALLY FIT MEDICALLY UNFIT FURTHER INFORMATION PROCESSED BY: _____

L 1. BLOOD PRESSURE: SYSTOLIC _____ DIASTOLIC _____

2. WEIGHT _____ LBS/KGS

K MEDICATION PLEASE ✓ CURRENT MEDICATION(S)

1 <input type="checkbox"/> NO MED	4 <input type="checkbox"/> ANTI-ANGINAL	7 <input type="checkbox"/> INSULIN
2 <input type="checkbox"/> SEDATIVE	5 <input type="checkbox"/> TRANQUILIZER	8 <input type="checkbox"/> ANTIHYPERTENSIVE
3 <input type="checkbox"/> NARCOTIC	6 <input type="checkbox"/> ANTICONVULSANT	
9 <input type="checkbox"/> OTHER _____		

M 1. VISUAL ACUITY:

	RIGHT	LEFT	BOTH
WITHOUT CORRECTIVE LENSES			
WITH CORRECTIVE LENSES			

2. VISUAL FIELDS (STATE IN DEGREES)

RIGHT _____ LEFT _____

DATE _____ SIGNATURE AND TITLE OF PERSON COMPLETING THE VISION TEST _____

It is recommended that you keep a copy of this document for your records

This information is requested by Manitoba Public Insurance pursuant to Section 18 of *The Drivers and Vehicles Act*. Manitoba Public Insurance will use the information you provide for the purposes specifically stated on this form, related purposes set out in *The Highway Traffic Act* and *The Drivers and Vehicles Act*, and for any other purposes authorized by law.

Pursuant to Section 18.2 of *The Drivers and Vehicles Act*, physicians and optometrists are required to report any driver who may have a disease or disability that may be expected to interfere with the safe operation of a motor vehicle.

To the Driver/Applicant:

Pursuant to Section 18(1) of *The Drivers and Vehicles Act*, a physician or nurse practitioner aware of your medical history must complete this report. Return the completed report to your nearest Manitoba Public Insurance Service Centre, or by fax or mail to the address on this form.

Please be advised:

- i. Pursuant to Section 18(5) or 18(8) of *The Drivers and Vehicles Act*, your driver's licence is subject to cancellation if you fail to comply within the time specified or, if you have a disease or disability that may interfere with the safe operation of a motor vehicle.
- ii. If your licence has been declassified, suspended or cancelled, Driver Fitness will notify you regarding your eligibility to hold a driver's licence only after the medical reports are submitted and reviewed.
- iii. If you are the holder of a Class 1-4 driver's licence and do **not** wish to maintain this licence class, please report to your nearest Autopac agent or Manitoba Public Insurance Service Centre to declass your licence. This report may still be required to maintain a Class 5 licence.
- iv. A vision screening (Section M) may be completed for no charge at your nearest Manitoba Public Insurance Service Centre or mobile testing unit. Visit mpi.mb.ca for locations.
- v. A vision screening is not a comprehensive eye examination. If your vision has deteriorated, please see your eye care practitioner. If the vision screening results do not meet the vision standards, a vision examination report may be requested.
- vi. The cost of a medical report requested by a third party, including any related examination, report, test or telephone call to the physician is not covered by Manitoba Health and is the responsibility of the individual concerned.
- vii. If you are applying for a Class 1-4 licence, this medical report is valid for six months from the date it was completed by your physician. If you do not obtain a Class 1-4 authorized instruction within that six-month period, an updated medical report will be required.

To the Examining Physician or Nurse Practitioner:

Please complete the report on reverse in full.

This personal health information will be disclosed by Manitoba Public Insurance to the individual upon request unless, in your opinion, knowledge of the information could reasonably be expected to endanger the health and safety of the individual or another person, or identify a third party. For detailed information concerning medical standards, please consult the Canadian Council of Motor Transport Administrators, Medical Standards for Drivers.

Based on the information in the medical report, Manitoba Public Insurance may forward a referral to the Health Sciences Centre, Driving Assessment and Management Program. You will be identified as the referring health care provider.

Your fee for completing this report is not covered by Manitoba Health or Manitoba Public Insurance.

Thank you for your cooperation,

Registrar of Motor Vehicles