Assessing fitness to drive 2022

Health Assessment for Commercial Vehicle Driver

FITNESS TO DRIVE REPORT

Note: This report should only be used for fitness for duty assessments conducted under schemes such as Trucksafe and NHVAS Fatigue Management Accreditation. It should not be used for licensing assessments – forms for this purpose will be provided by the licensing authority.

Driver information:

Surname:	Given name(s):
Address:	
Date of birth:	Phone:
Driver licence number:	State of issue:

Employer information:

Employer:	Contact name:
Address:	
Phone:	Contact email:

Nature of driving duties (type of vehicle, hours and distances of driving, purpose of driving):

Assessment outcome:

I was familiar with the driver's medical history before conducting this assessment ☐ Yes ☐ No

I have sighted the driver's licence ☐ Yes ☐ No

This report is (select one):

☐ An interim report pending further investigation ☐ A final report of the driver's fitness to drive status

I have examined the driver in accordance with Assessing Fitness to Drive 2022 standards for commercial vehicle drivers, and in my opinion: (tick ONE box and indicate recommended management overleaf):

☐ **UNCONDITIONALLY meets the medical criteria for fitness to drive**

The driver meets all relevant medical criteria. No restrictions or conditions.

They should be reviewed in line with the prescribed schedule – ***see overleaf***.

☐ **CONDITIONALLY meets the medical criteria for fitness to drive**

The driver has a medical condition that may impact on fitness to drive, but it is well controlled and meets the **conditional** criteria in *Assessing Fitness to Drive 2022.*

Periodic review may be required – ***see recommended review date overleaf.***

Aids required for fitness to drive (tick if applicable):

☐ Corrective lenses

☐ Hearing aid

☐ Other aids/devices (specify):

Management and review – see overleaf

☐ **TEMPORARILY does not meet the medical criteria for fitness to drive**

The driver does not meet relevant medical criteria (Unconditional or Conditional) and should not undertake normal driving duties. They may perform alternative (non-driving) tasks. They may return to driving following: an improvement in condition, response to treatment or confirmed diagnosis of undifferentiated illness.

Estimated time off duty: *days/weeks/months*

Management and review – see overleaf

☐ **PERMANENTLY does not meet the medical criteria for fitness to drive**

The driver does not meet relevant medical criteria and cannot perform normal driving duties in the foreseeable future.

THE FORM SHOULD BE COMPLETED BY THE EXAMINING HEALTH PROFESSIONAL AND PROVIDED TO THE REQUESTING ORGANISATION/DRIVER

A COPY SHOULD BE RETAINED BY THE EXAMINING HEALTH PROFESSIONAL

Recommended management

I recommend and/or have actioned the following:

- ☐ Local doctor referral
- ☐ Specialist referral
- ☐ Drug test
- ☐ Practical driver test
- ☐ Other, please describe:

Recommended review

- ☐ Next assessment as per prescribed schedule
- ☐ Recommend more frequent review (timeframe of next review (from date of assessment): *month/years*

Other comments:

Health professional's details (stamp accepted):

Surname:	Given name(s):
Practice address:	
Phone:	Facsimile:

Signature:	Date of assessment:

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CLINICAL ASSESSMENT RECORD

Driver information:

Surname:	Given name(s):
Address:	
Date of birth:	Phone:
Driver licence number:	State of issue:

Employer information:

Employer:	
Address:	
Contact name:	Phone:
Contact email	

Nature of driving duties (type of vehicle, hours and distances of driving, purpose of driving):

CLINICAL ASSESSMENT:

The patient has been assessed to the following AFTD standard:

☐ Commercial vehicle driver

Health assessment history

Date of driver's last fitness to drive assessment Date: ☐ Not applicable or not known

Health professional comments:

1. Vision

1.1 Visual acuity (refer AFTD, page 201, 210)

Are glasses or contact lenses worn? ☐ Yes ☐ No

	R	L	Both
Without Correction	6 /	6 /	6 /
With Correction	6 /	6 /	6 /

Meets criteria ☐ Without correction ☐ With correction

Does not meet criteria ☐

1.2 Visual Fields ☐ Normal ☐ Abnormal (refer AFTD, page 203-204, 209)

Health professional comments:

2. Hearing (refer AFTD, page 105-109 including flowchart)

Assess clinically in the first instance. Audiometry is only required if clinical assessment indicates possible hearing loss.
(Clinical tests used to screen for hearing impairment include testing whether a person can hear a whispered voice, a finger rub, or a watch tick at a specific distance. Perceived hearing loss can be assessed by asking a single question (for example, "Do you have difficulty with your hearing?" as per the Driver Health Questionnaire)

Possible hearing loss? ☐ Yes ☐ No

If yes, are hearing aids worn? ☐ Yes ☐ No

Refer for audiometry if indicated:

Hearing level at frequencies (db)

	0.5kHz	1.0kHz	1.5kHz	2.0kHz	3.0kHz	4.0kHz	6.0kHz	8.0kHz	Average of 0.5,1,2,3 kHz
Right ear									
Left ear									

Meets criteria ☐ Without hearing aid ☐ With hearing aid

Does not meet criteria ☐

Health professional comments:

3. Cardiovascular system (refer AFTD page 63-91)

Relevant findings from questionnaire:

Blood pressure	Repeated (if necessary)
Systolic	Systolic
Diastolic	Diastolic

Pulse rate beats/min ☐ Normal ☐ Abnormal

Heart sounds ☐ Normal ☐ Abnormal

Peripheral pulses ☐ Normal ☐ Abnormal

Health professional comments (including comments regarding overall cardiac risk and risk factors e.g. obesity, smoking, exercise, stress):

4. Diabetes (Refer AFTD page 92-104)

Existing diabetes? ☐ No ☐ Yes

Health professional comments including comments about hypoglycaemia awareness and end organ effects and impact on driving:

5. Musculoskeletal / neurological system (Refer AFTD page 112-119, 120-166)

Relevant findings from questionnaire including existing neurological and musculoskeletal conditions and impact on driving:

Cervical spine rotation		☐ Normal	☐ Abnormal
Back movement		☐ Normal	☐ Abnormal
Upper limbs:	(a) Appearance	☐ Normal	☐ Abnormal
	(b) Joint movements	☐ Normal	☐ Abnormal
Lower limbs:	(a) Appearance	☐ Normal	☐ Abnormal
	(b) Joint movements	☐ Normal	☐ Abnormal
Reflexes		☐ Normal	☐ Abnormal
Romberg's sign*		☐ Normal	☐ Abnormal

(* A pass requires the ability to maintain balance while standing with shoes off, feet together side by side, eyes closed and arms by sides, for thirty seconds)

Functional/ practical assessment required? ☐ No ☐ Yes

Health professional comments including any impacts of chronic pain:

6. Psychological health (Refer AFTD page 170-176)

Relevant findings from questionnaire:

Mental state examination:

Appearance	☐ Normal	☐ Abnormal
Attitude	☐ Normal	☐ Abnormal
Behaviour	☐ Normal	☐ Abnormal
Mood and affect	☐ Normal	☐ Abnormal
Thought form stream and content	☐ Normal	☐ Abnormal
Perception	☐ Normal	☐ Abnormal
Cognition	☐ Normal	☐ Abnormal
Insight	☐ Normal	☐ Abnormal
Judgement	☐ Normal	☐ Abnormal

Health professional comments:

7. Sleep disorders (Refer AFTD page 179-186)

Existing sleep disorder? ☐ No ☐ Yes

ESS Score (Screen):
(Q 5 of Driver Health Questionnaire)

(Score = 16 to 24 is consistent with moderate to severe excessive daytime sleepiness. Do not rely solely on the ESS to rule out sleep apnoea)

Other relevant findings from questionnaire:

Clinical signs of sleep disorder ☐ Absent ☐ Present

Health professional comments:

8. Substance misuse (Refer AFTD page 190 -197)

Note: Drug screening not routinely required.

Existing substance use disorder? ☐ No ☐ Yes

Audit Score (Screen):
(Q6 of Driver Health Questionnaire)

(Score > 8 indicates strong likelihood of hazardous or harmful alcohol consumption)

Other relevant findings from questionnaire:

Clinical signs of substance misuse ☐ Absent ☐ Present

Health professional comments:

9. Medication (Prescription and OTC)

Specify:

SUMMARY:

Summarise significant findings

Are any further investigations or referrals required? ☐ Yes (describe) ☐ No

What is the recommendation for this driver in terms of fitness to drive?

☐ **Unconditionally** meets the medical criteria – meets all relevant medical criteria (no restrictions)

☐ **Conditionally** meets the medical criteria for fitness to drive – has a medical condition that may impact on fitness to drive but it is well controlled and meets the conditional criteria in *Assessing Fitness to Drive 2022*. Indicate also if:

☐ Driver requires aids to drive:

☐ Vision aids ☐ Hearing aids ☐ Other devices or vehicle modifications (specify)

☐ Driver requires more frequent review than prescribed under normal periodic review:

Specify recommended review:

☐ **Temporarily** does not meet the medical criteria (unconditional or conditional) – pending further investigation and treatment (record details).

☐ **Permanently** does not meet the medical criteria (record details)

Contact(s) with other treating health professional(s)

Note: Contact is to be made with patient's consent as per questionnaire

Contact with requesting organisation (if relevant and clinically warranted)

☐ If the driver is classified *Temporarily or Permanently does not meet the medical criteria*, send Fitness to Drive Report immediately to requesting organisation, if relevant and advise driver accordingly.

Details of contact made

Name of doctor	Signature of doctor	Date

Assessing fitness to drive 2022

Health Assessment for Commercial Vehicle Driver

DRIVER HEALTH QUESTIONNAIRE

(to be completed by driver)

Health assessment history:

Please note the date of your last fitness to drive assessment Date: ☐ Not applicable or not known

Driver information:

Surname:	Given name(s):
Address:	
Date of birth:	Phone:
Driver licence number:	State of issue:

Employer information:

Employer:	
Address:	
Contact name:	Phone:
Contact email	

Instructions to driver:

Please answer the questions by ticking the appropriate box and providing details as requested. If you are not sure what a question means, leave the answer blank and the health professional will help you. The health professional will ask you additional questions during the assessment.

Please bring with you to the assessment:

- A list of current prescription, non-prescription and complementary medicines
- Glasses/contact lenses and hearing aids if you use them
- Disease management plans (e.g. sleep disorder management plan, diabetes management plan)

On completion of the questionnaire, you will be asked to sign a declaration to confirm the accuracy of your responses. You will also be asked to provide your consent if the health professional requests to make contact with your treating health professional(s) to help clarify your medical management as required to determine fitness to drive.

Management of your health information:

Please read carefully and sign the declaration on the last page to indicate you understand how health information is reported, stored and accessed.

Your health information may only be collected and disclosed for the purpose of managing your fitness to drive a commercial vehicle. This means that details of your health assessment will remain confidential and will only be reported to the requesting organisation in terms of your fitness to drive.

The examining health professional retains all detailed health documentation including your questionnaire responses and the completed record of clinical findings. The examining health professional will provide you with the report form to return to the requesting organisation indicating your fitness for duty classification. If you are assessed as unfit to drive, the examining doctor will advise you and contact the requesting organisation straight away.

Other than the above, your personal information will not be disclosed to any other person or organisation without your written permission, except when required by law.

You have the right to access your health records including those held by the examining health professional and the reports held by the requesting organisation.

Questions:

1.	Are you currently attending a health professional for any illness, injury or disability?	☐ No ☐ Yes
2.	Are you taking any prescription, non-prescription or complementary medicines?	☐ No ☐ Yes

If **YES** to Question 1 or 2 please provide brief details:

Health professional comments:

3. Do you suffer from or have you ever suffered from any of the following:

3.1	High blood pressure	☐ No ☐ Yes	**3.11**	Stroke	☐ No ☐ Yes
3.2	Heart disease	☐ No ☐ Yes	**3.12**	Dizziness, vertigo, problems with balance	☐ No ☐ Yes
3.3	Chest pain, angina	☐ No ☐ Yes	**3.13**	Memory loss or difficulty with attention or concentration	☐ No ☐ Yes
3.4	Any condition requiring heart surgery	☐ No ☐ Yes	**3.14**	Other neurological or neurodevelopmental disorder	☐ No ☐ Yes
3.5	Palpitations / irregular heartbeat	☐ No ☐ Yes	**3.15**	Neck, back or limb disorders	☐ No ☐ Yes
3.6	Abnormal shortness of breath	☐ No ☐ Yes	**3.16**	Double vision, difficulty seeing	☐ No ☐ Yes
3.7	Diabetes	☐ No ☐ Yes	**3.17**	Colour blindness	☐ No ☐ Yes
3.8	Head injury, spinal injury	☐ No ☐ Yes	**3.18**	Hearing loss or deafness or had an ear operation or use a hearing aid	☐ No ☐ Yes
3.9	Seizures, fits, convulsions, epilepsy	☐ No ☐ Yes	**3.19**	A psychiatric illness or nervous disorder	☐ No ☐ Yes
3.10	Blackouts or fainting	☐ No ☐ Yes			

Health professional comments:

4.	Have you ever had any other serious injury, illness, disability, operation or accident or been in hospital for any reason?	☐ No ☐ Yes

Please describe:

Health professional comments:

5. Sleep

5.1	Have you ever been tested for a sleep disorder or been told by a doctor that you have a sleep disorder, sleep apnoea or narcolepsy?	☐ No ☐ Yes
5.2	Are you aware or have you been told that you snore loudly?	☐ No ☐ Yes
5.3	Has anyone told you that your breathing stops or is disrupted by episodes of choking during your sleep?	☐ No ☐ Yes

5.4	How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? *This refers to your usual way of life in recent times. If you haven't done some of these things recently try to work out how they would have affected you.*	would never doze off (0)	slight chance of dozing (1)	moderate chance of dozing (2)	high chance of dozing (3)
a	Sitting and reading	☐	☐	☐	☐
b	Watching TV	☐	☐	☐	☐
c	Sitting inactive in a public place (e.g. a theatre or a meeting)	☐	☐	☐	☐
d	As a passenger in a car for an hour without a break	☐	☐	☐	☐
e	Lying down to rest in the afternoon when circumstances permit	☐	☐	☐	☐
f	Sitting and talking to someone	☐	☐	☐	☐
g	Sitting quietly after a lunch without alcohol	☐	☐	☐	☐
h	In a car, while stopped for a few minutes in the traffic	☐	☐	☐	☐

Health professional comments:

6. Alcohol and other drugs

6.1	Have you ever sought assistance for alcohol or substance use issues?	☐ No ☐ Yes

6.2	**Please circle the answer that best describes your situation.**	(0)	(1)	(2)	(3)	(4)
a	How often do you have a drink containing alcohol?	Never ☐	Monthly or less ☐	2 to 4 times per month ☐	2 to 3 times per week ☐	4 + times per week ☐
b	How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2 ☐	3 to 5 ☐	5 to 6 ☐	7 to 9 ☐	10 or more ☐
c	How often do you have six or more drinks on one occasion?	Never ☐	Monthly or less ☐	2 to 4 times per month ☐	2 to 3 times per week ☐	4 + times per week ☐
d	How often during the last year have you found that you were not able to stop drinking once you had started?	Never ☐	Monthly or less ☐	2 to 4 times per month ☐	2 to 3 times per week ☐	4 + times per week ☐
e	How often during the last year have you failed to do what was normally expected from you because of drinking?	Never ☐	Monthly or less ☐	2 to 4 times per month ☐	2 to 3 times per week ☐	4 + times per week ☐
f	How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never ☐	Monthly or less ☐	2 to 4 times per month ☐	2 to 3 times per week ☐	4 + times per week ☐
g	How often during the last year have you had a feeling of guilt or remorse after drinking?	Never ☐	Monthly or less ☐	2 to 4 times per month ☐	2 to 3 times per week ☐	4 + times per week ☐
h	How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never ☐	Monthly or less ☐	2 to 4 times per month ☐	2 to 3 times per week ☐	4 + times per week ☐
i	Have you or someone else been injured as a result of your drinking?	No ☐		Yes, but not in the last year ☐		Yes, during the last year ☐

		No	Yes, but not in the last year	Yes, during the last year
j	Has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?	☐	☐	☐

Health professional comments:

Other drugs

6.3	Do you currently use illicit drugs?	☐ No ☐ Yes
6.4	Do you use any drugs or medications not prescribed for you by your doctor?	☐ No ☐ Yes

Please describe:

6.5	Have you tested positive for drugs or alcohol in the period since your last assessment?	☐ No ☐ Yes

Health professional comments:

7.	Have you been in a vehicle crash or had a near miss since your last fitness to drive examination?	☐ No ☐ Yes

Health professional comments:

Driver's declaration – accuracy and completeness of information provided

To the best of my knowledge the answers given above are accurate and complete:

Signature of driver

Date

Signature of examining doctor

Date

Driver's declaration

I have read and understood the statement concerning the health information provided in this document.

Signature of driver

Date

Consent to contact treating health professionals

I consent to the examining doctor contacting my treating health professionals to clarify aspects of my medical management.

Signature of driver

Date