|  |
| --- |
| ***Basic Fatigue Management Medical Certificate Process***  ***Information for the driver / applicant (ASSESSING FITNESS TO DRIVE 2016)***    ***Driver Health Questionnaire (Pages 2 – 5)***  The *Driver Health Questionnaire* is a screening tool to help identify conditions that might affect a person’s capacity to drive safely. It is completed by the driver prior to the health assessment.  The questionnaire is not a diagnostic tool and no decision can be made regarding the person’s fitness to drive until a full clinical examination is performed.  The examining doctor will need to review the answers with the applicant to ascertain relevant details and guide the clinical examination, including the conduct of additional tests.  Dishonest completion of the questionnaire may be an issue. Drivers are required to sign the completed questionnaire in the presence of the examining doctor as a declaration of the completeness and accuracy of the information. The doctor then countersigns. If the driver refuses to sign, the examination should not proceed.  The driver will also sign the declaration regarding disclosure of information to acknowledge that they understand and agree with how their health information will be used.  The form should be retained by the doctor and filed in the driver’s medical record. For privacy reasons, it should not be returned to the requesting organisation, if there is one. *Information for the examining doctor**Clinical Assessment Record (Pages 6 – 8)*  The *Clinical Assessment Record* is a tool to guide the health assessment process. It provides a standard format for recording the results of the assessment and the reasons for the fitness to drive conclusions.  The doctor records the results of the assessment and retains the form (Pages 2 to 8) in the driver’s confidential medical record. The doctor may give a full copy of the report back to the patient.  The assessment is to be conducted in accordance with the Austroads “Assessing Fitness to Drive – 2016” standards, a copy of the standards are available on the Austroads website (www.austroads.com.au) *Basic Fatigue Management – Fitness to Drive Report (Page 9)*  The doctor will then summarise the results in terms of the driver meeting the medical criteria on the *Fitness to Drive Report* form (Page 9). This page is required to be provided to the patient’s employer.  For privacy reasons, the completed *Clinical Assessment* *Record* must not be forwarded to the requesting organisation, if there is one.    [*www.massmanagement.com.au*](http://www.massmanagement.com.au)  *Specialist advice on NHVAS, Mass, Maintenance & BFM Accreditation*  *PBS, Access Permits, Work Diaries, Heavy Vehicle Operations and Compliance*  [*info@massmanagement.com.au*](mailto:info@massmanagement.com.au)*, Freecall 1300 35 00 89*    **IN-CONFIDENCE WHEN COMPLETED**  **PAGES 2 – 8 SHOULD BE RETAINED BY THE EXAMINING HEALTH PROFESSIONAL** |
| **Assessing Fitness to Drive 2016**  **Health Assessment for Commercial Vehicle Driver** |

**DRIVER HEALTH QUESTIONNAIRE**

**(to be completed by driver and provided to the examining doctor)**

**Driver information:**

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

**Employer information:**

|  |  |
| --- | --- |
| Employer name: | |
| Address: | Phone: |

**Instructions for completion:**

Please answer the questions by ticking the appropriate box. 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. On completion of the questionnaire you will be asked to sign a declaration to confirm the accuracy of your responses.

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)

**Disclosure of health information:**

**Please read carefully and sign to indicate you understand how health information is reported, stored and accessed.**

The details of your health assessment will remain confidential and will only be reported to the requesting organisation in terms of whether you meet the medical criteria for driving a commercial vehicle. 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. 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.

**Driver’s declaration**

I have read and understood the above 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

|  |  |  |
| --- | --- | --- |
|  |  |  |

**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’s 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 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’s comments:** | | | | | |
| **4.** | Have you ever had any other serious injury, illness, disability, operation or accident or been in hospital for any reason? (please describe). | | | | No  Yes |

**Health professional’s 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** | Has anyone told you that your breathing stops or is disrupted by episodes of choking during your sleep? | No  Yes |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **5.3** | | 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’s comments:** | | | | | | | | | | | |
| **6.** | **Alcohol** | |  |  | |  | |  | |  | |
| **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 or more 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 | | 2-3 times per week | | >3 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 | | 2-3 times per week | | >3 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 | | 2-3 times per week | | >3 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 | | 2-3 times per week | | >3 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 | | 2-3 times per week | | >3 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 | | 2-3 times per week | | >3 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 | |
| **j** | Has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down? | | No |  | | Yes, but not in the last year | |  | | Yes, during the last year | |
| **Health professional’s comments** | | | | | | | | | | | |

|  |  |  |
| --- | --- | --- |
|  | | |
| **Other** | | |
| **7.** | Do you currently use illicit drugs? | No  Yes |
| **8.** | Do you use any drugs or medications not prescribed for you by your doctor? | No  Yes |
| **9.** | Have you been in a vehicle crash since your last fitness to drive examination? | No  Yes |
| **Health professional’s 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

|  |  |  |
| --- | --- | --- |
|  |  |  |

**CLINICAL ASSESSMENT RECORD**

**IN-CONFIDENCE WHEN COMPLETED**

**PAGES 2 – 8 SHOULD BE RETAINED BY THE HEALTH PROFESSIONAL**

**Driver information:**

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

**Employer information:**

|  |  |
| --- | --- |
| Employer name: | |
| Address: | Phone: |

**Nature of driving duties:**

|  |
| --- |
|  |

**CLINICAL ASSESSMENT:**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **1.** | **Vision** | | | | | | | |
| **1.1 Visual acuity** (refer AFTD, page 124, 129) | | | | | | | | |
| 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 125-26, 128) |

**Comments:**

|  |
| --- |
|  |

|  |  |
| --- | --- |
| **2.** | **Hearing** (refer AFTD, page 67-69 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 |  | | | | | |  | | | |  | | | |
| **Comments:** | | | | | | | | | | | | | | |

|  |  |
| --- | --- |
| **3.** | **Cardiovascular system** (refer AFTD page 39-58) |

**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 |

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

|  |
| --- |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| **4.** | **Diabetes** (Refer AFTD page 59-66) | | |
| **Existing diabetes?** | | No | Yes |

**Comments:**

|  |
| --- |
|  |

|  |  |
| --- | --- |
| **5.** | **Musculoskeletal / neurological system**  (Refer AFTD page 71-75, 76-105) |

**Comments** include relevant findings from questionnaire including existing neurological and musculoskeletal conditions:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | | | | | | |
| 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 |

**Comments:**

|  |  |
| --- | --- |
|  |  |

|  |  |
| --- | --- |
| **6.** | **Psychological health** (Refer AFTD page 107-110) |

**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 |

**Comments:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | | | | |
| **7.** | **Sleep disorders** (Refer AFTD page 112-115) | | |
| **Existing sleep disorder?**  No  Yes | | | |
| **ESS Score (Screen):** (Q 5 of Driver Health Questionnaire) | | |  |
|  | | | |
| (Score > 16 is consistent with moderate to severe excessive daytime sleepiness. Do not rely solely on the ESS to rule out sleep apnoea) | | | |
|  | | | |
| **Clinical signs of sleep disorder** | | Absent | Present |

**Comments:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | | | | |
| **8.** | **Substance misuse** (Refer AFTD page 117 -121) | | | |
| 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) | | | | |
|  | | | | |
| **Clinical signs of substance misuse** | | Absent | Present | |

**Comments:**

|  |
| --- |
|  |

|  |  |
| --- | --- |
| **9.** | **Medication** |
| 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 2016*. 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. | Details of contact made |

Name of doctor Signature of doctor Date

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | | |  |  | | | |  |  | | |
| **THIS PAGE TO BE COMPLETED BY THE EXAMINING DOCTOR AND PROVIDED TO THE REQUESTING ORGANISATION/DRIVER A COPY SHOULD BE RETAINED BY THE EXAMINING DOCTOR** | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
|  | **Basic Fatigue Management - FITNESS TO DRIVE REPORT**  **(Note: this report relates to the driver’s fitness for duty and is not to be used for driver licensing assessments)** | | | | | | | | | | | |  | |
|  | | | | | | | | | | | | | | |
| **Driver information:** | | Surname: | | | | | | Given name(s): | | | | | | |
| Address: | | |  | | | | | | | | | | | |
| Phone: | | |  | Date of birth: | | | Driver licence no. | | | | | State of issue: | | |
| **Employer information:** | | Name: | | | | | | | | | | | | |
| Address: | | | | | | | | | Contact phone number: | | | | | |
| **Nature of driving duties:** | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |

|  |  |  |
| --- | --- | --- |
| **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 | | |
| **I have examined the driver in accordance with the Assessing Fitness to Drive 2016 standards for commercial vehicle drivers. In my opinion the driver (tick ONE box from 1 to 4 and indicate recommended management and timing of next review):** | | |
|  | 1. **Unconditionally meets the medical criteria for fitness to drive**   Meets all relevant medical criteria. No restrictions or conditions. See **timing of next review** below. | |
|  | 1. **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 inAssessing Fitness to Drive 2016*.* May require person to be reviewed more frequently than standard. See **recommended management** and **timing of next review** below.  Person is required to wear the following aids/devices:  Corrective lenses  Hearing aid  Other aids/devices (specify): | |
|  | 1. **Temporarily does not meet the medical criteria for fitness to drive**   Does not meet relevant medical criteria (unconditional or conditional) and should not undertake normal driving duties. May perform alternative tasks. May return to driving following: an improvement in condition, response to treatment or confirmed diagnosis of undifferentiated illness. See **recommended management** and **timing of next review** below. | |
|  | 1. **Permanently does not meet the medical criteria for fitness to drive**   Does not meet relevant medical criteria and cannot perform normal driving duties in the foreseeable future. | |
|  | **Recommended management:**  Local doctor referral  Specialist referral  Laboratory tests  Drug test | Shorter review interval than standard (see **timing of next review** below)  Other, please describe (attach information to the form if required) |

|  |  |
| --- | --- |
| **Timing of next review (from date of assessment):** |  |
| 1 year (NHVAS & TruckSafe standard for 50 years and over) | 3 years (NHVAS & TruckSafe standard for 49 years and under) |
| Shorter review interval than standard (specify): years / months / weeks (circle or highlight) | |

|  |  |  |
| --- | --- | --- |
| **Health professional’s details** | | |
| Name: | Phone: | Facsimile: |
| Practice address: | | |
| Signature: | Date of assessment: | |