

SECTION 1: APPLICANT DETAILS (to be completed by Applicant)			
Surname:			
Given Name(s):			Date of Birth:
Address:			
Contact Number:		Email:	

I have made the medical practitioner completing this form aware of any medical condition that I have and drugs or medication that I use. I consent to my medical practitioner and/or my treating specialist releasing to the Matrix Training any medical information relating to my ability to drive safely.

Student Sign:	Date:
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A person must not, in providing information, make a statement that is false or misleading.

Please note: Your medical practitioner has a legal obligation to inform if they believe that a person they have examined is suffering from a medical condition such that they may endanger the public if they drove.

SECTION 2: IMPORTANT NOTES FOR THE MEDICAL PRACTITIONER
<p>Matrix Training requires the applicants to provide evidence of their fitness to drive. Please:</p> <ul style="list-style-type: none"> refer to the National Transport Commission's publication "Assessing Fitness to Drive" private standards for light vehicle licence (your assessment must be undertaken in accordance with the guidelines); please complete all of sections 3 and 5; please complete section 4 if your patient has a vision or eye disorder, or is required to wear glasses or corrective lenses; provide comment in the notes section on how well controlled your patient's condition(s) are and compliance with any medication taking.

SECTION 3: MEDICAL EXAMINATION REPORT (to be completed by Medical Practitioner)																		
1. BLACKOUT																		
<p>Has your patient experienced a blackout? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If Yes, Date of most recent episode: _____</p>																		
2. CARDIOVASCULAR CONDITION																		
<p>Does the patient have a cardiovascular condition or has the patient undergone a cardiovascular procedure?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If Yes, please tick the relevant condition(s):</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Acute Myocardial Infarction (AMI)</td> <td><input type="checkbox"/> Angina (If Unstable)</td> <td><input type="checkbox"/> Atrial Fibrillation (AF)</td> </tr> <tr> <td><input type="checkbox"/> Cardiac Aneurysm</td> <td><input type="checkbox"/> Cardiac Arrest</td> <td><input type="checkbox"/> Cardiac Pacemaker</td> </tr> <tr> <td><input type="checkbox"/> Congenital Heart Disorder</td> <td><input type="checkbox"/> Coronary Artery Bypass Grafting (CABG)</td> <td><input type="checkbox"/> Dilated Cardiomyopathy</td> </tr> <tr> <td><input type="checkbox"/> Heart Failure</td> <td><input type="checkbox"/> Heart Transplant</td> <td><input type="checkbox"/> Hypertrophic Cardiomyopathy</td> </tr> <tr> <td colspan="3"><input type="checkbox"/> Percutaneous Coronary Intervention (PCI or Angioplasty)</td> </tr> <tr> <td colspan="3"><input type="checkbox"/> Other (please specify): _____</td> </tr> </table>	<input type="checkbox"/> Acute Myocardial Infarction (AMI)	<input type="checkbox"/> Angina (If Unstable)	<input type="checkbox"/> Atrial Fibrillation (AF)	<input type="checkbox"/> Cardiac Aneurysm	<input type="checkbox"/> Cardiac Arrest	<input type="checkbox"/> Cardiac Pacemaker	<input type="checkbox"/> Congenital Heart Disorder	<input type="checkbox"/> Coronary Artery Bypass Grafting (CABG)	<input type="checkbox"/> Dilated Cardiomyopathy	<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Heart Transplant	<input type="checkbox"/> Hypertrophic Cardiomyopathy	<input type="checkbox"/> Percutaneous Coronary Intervention (PCI or Angioplasty)			<input type="checkbox"/> Other (please specify): _____		
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3. HYPERTENSION																		
<p>Does your patient have blood pressure consistently greater than 200 systolic or greater than 110 diastolic (treated or untreated)? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Blood pressure readings: Systolic: _____ Diastolic: _____</p>																		
4. DIABETES																		
<p>Does your patient have diabetes controlled by medication? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If Yes, please inform if Diabetes is controlled by: <input type="checkbox"/> Insulin <input type="checkbox"/> Tablet</p> <p>Date of last severe hypoglycaemic episode if applicable: _____</p>																		
5. HEARING LOSS																		
<p>Does your patient have severe hearing loss? <input type="checkbox"/> No <input type="checkbox"/> Yes</p>																		
6. MUSCULOSKELETAL CONDITION																		
<p>Does your patient have a musculoskeletal condition? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If Yes, please tick the relevant condition(s): <input type="checkbox"/> Severe Arthritis <input type="checkbox"/> Limb</p> <p>Other Musculoskeletal Conditions (specify condition) _____</p>																		
7. NEUROLOGICAL / NEUROMUSCULAR CONDITIONS																		
<p>Does your patient have a neurological / neuromuscular condition? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If Yes, please tick the relevant condition(s):</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;"><input type="checkbox"/> Brain Aneurysm</td> <td style="width: 33%;"><input type="checkbox"/> Cerebral Palsy</td> <td style="width: 33%;"><input type="checkbox"/> Dementia</td> </tr> <tr> <td><input type="checkbox"/> Epilepsy, Date of last episode: _____</td> <td><input type="checkbox"/> Head Injury</td> <td><input type="checkbox"/> Multiple Sclerosis</td> </tr> <tr> <td><input type="checkbox"/> Muscular Dystrophy</td> <td><input type="checkbox"/> Parkinson's Disease</td> <td><input type="checkbox"/> Stroke</td> </tr> <tr> <td><input type="checkbox"/> Seizure, Date of last episode: _____</td> <td colspan="2"><input type="checkbox"/> Space-occupying Lesion (brain tumour), Date of last episode: _____</td> </tr> <tr> <td colspan="3"><input type="checkbox"/> Subarachnoid Haemorrhage, Date of last episode: _____</td> </tr> <tr> <td colspan="3"><input type="checkbox"/> Other (please specify): _____</td> </tr> </table>	<input type="checkbox"/> Brain Aneurysm	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Dementia	<input type="checkbox"/> Epilepsy, Date of last episode: _____	<input type="checkbox"/> Head Injury	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Muscular Dystrophy	<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Stroke	<input type="checkbox"/> Seizure, Date of last episode: _____	<input type="checkbox"/> Space-occupying Lesion (brain tumour), Date of last episode: _____		<input type="checkbox"/> Subarachnoid Haemorrhage, Date of last episode: _____			<input type="checkbox"/> Other (please specify): _____		
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<input type="checkbox"/> Other (please specify): _____																		
8. PSYCHIATRIC CONDITION																		
<p>Does your patient have a severe mental health/nervous condition? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If Yes, please tick the relevant condition(s):</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;"><input type="checkbox"/> Post-Traumatic Stress Disorder (PTSD)</td> <td style="width: 33%;"><input type="checkbox"/> Schizophrenia</td> <td style="width: 33%;"><input type="checkbox"/> Personality Disorder</td> </tr> <tr> <td><input type="checkbox"/> Chronic Anxiety</td> <td colspan="2"><input type="checkbox"/> Chronic Depression</td> </tr> <tr> <td colspan="3"><input type="checkbox"/> Other: _____</td> </tr> </table> <p>Does your patient require medication? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If Yes - is your patient compliant with medication? <input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<input type="checkbox"/> Post-Traumatic Stress Disorder (PTSD)	<input type="checkbox"/> Schizophrenia	<input type="checkbox"/> Personality Disorder	<input type="checkbox"/> Chronic Anxiety	<input type="checkbox"/> Chronic Depression		<input type="checkbox"/> Other: _____											
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<input type="checkbox"/> Other: _____																		

9. SLEEP DISORDER
<p>Does your patient have a sleep disorder? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If Yes, please complete the following:</p> <p><input type="checkbox"/> Established Sleep Apnoea Syndrome <input type="checkbox"/> Narcolepsy</p> <p>Other: _____</p>
10. SUBSTANCE MISUSE
<p>Does your patient currently misuse alcohol or drugs? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If Yes, complete the following:</p> <p><input type="checkbox"/> Alcohol <input type="checkbox"/> Illicit drugs <input type="checkbox"/> Prescription drugs</p>

SECTION 4: EYESIGHT CERTIFICATE (Only complete questions 11 and 12 if your patient has a vision or eye disorder, or is required to wear glasses or corrective lenses)			
11. Does your patient have one or more of the following vision or eye disorders?			
<input type="checkbox"/> Diplopia	<input type="checkbox"/> Monocular Vision	<input type="checkbox"/> Visual Field Defect	<input type="checkbox"/> Retinitis Pigmentosa
Note: If any of the above is ticked, the eyesight certificate must be completed by an Optometrist or Ophthalmologist.			
Does your patient have one or more of the following vision or eye disorders?			
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Macular Degeneration	
<input type="checkbox"/> Other vision or eye disorder which may impair their ability to drive (please specify): _____			
12. Visual acuity			
	Right	Left	Together
Uncorrected	_____	_____	_____
Corrected (glasses/contacts)	_____	_____	_____
Note: If the patient's visual acuity with corrective lenses in the better eye or with both eyes together is worse than 6/12, this section must be completed by an Optometrist or Ophthalmologist. (Refer to Vision and Eye disorders in " Assessing Fitness to Drive " publication.)			
Does your patient meet the eyesight standards in the Assessing Fitness to Drive guidelines? <input type="checkbox"/> No <input type="checkbox"/> Yes			
Are glasses or contact lenses required for driving? <input type="checkbox"/> No <input type="checkbox"/> Yes			
Should a condition be placed on the licence? <input type="checkbox"/> No <input type="checkbox"/> Yes			
(e.g. daylight hours only). If Yes , is ticked, please provide details below:			

Medical Practitioner name:	Optometrist/Ophthalmologist name:
Signature and Date:	Signature and Date:
Contact:	Contact:

