MATRIX TRAINING

Certificate of Fitness (VIC)
Light Vehicle (Private) Driver

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:**

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

Matrix Training requires the applicants to provide evidence of their fitness to drive. Please:

- refer to the Safe Transport Victoria's publication "Assessing fitness to drive" medical standards for commercial and private vehicle drivers (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

Has your patient experienced a blackout? ☐ **No** ☐ **Yes**

If **Yes**, Date of most recent episode: _____

2. CARDIOVASCULAR CONDITION

Does the patient have a cardiovascular condition or has the patient undergone a cardiovascular procedure?

☐ **No** ☐ **Yes**

If **Yes,** please tick the relevant condition(s):

☐ Acute Myocardial Infarction (AMI) ☐ Angina (If Unstable) ☐ Atrial Fibrillation (AF)

☐ Cardiac Aneurysm ☐ Cardiac Arrest ☐ Cardiac Pacemaker

☐ Congenital Heart Disorder ☐ Coronary Artery Bypass Grafting (CABG) ☐ Dilated Cardiomyopathy

☐ Heart Failure ☐ Heart Transplant ☐ Hypertrophic Cardiomyopathy

☐ Percutaneous Coronary Intervention (PCI or Angioplasty)

☐ Other (please specify): _____

3. HYPERTENSION

Does your patient have blood pressure consistently greater than 200 systolic or greater than 110 diastolic (treated or untreated)? ☐ **No** ☐ **Yes**

Blood pressure readings:

Systolic: _____ Diastolic: _____

4. DIABETES

Does your patient have diabetes controlled by medication? ☐ **No** ☐ **Yes**

If **Yes**, please inform if Diabetes is controlled by: ☐ Insulin ☐ Tablet

Date of last severe hypoglycaemic episode if applicable: _____

5. HEARING LOSS

Does your patient have severe hearing loss? ☐ **No** ☐ **Yes**

6. MUSCULOSKELETAL CONDITION

Does your patient have a musculoskeletal condition? ☐ **No** ☐ **Yes**

If **Yes**, please tick the relevant condition(s): ☐ Severe Arthritis ☐ Limb

Other Musculoskeletal Conditions (specify condition) _____

7. NEUROLOGICAL / NEUROMUSCULAR CONDITIONS

Does your patient have a neurological / neuromuscular condition? ☐ **No** ☐ **Yes**

If **Yes**, please tick the relevant condition(s):

☐ Brain Aneurysm ☐ Cerebral Palsy ☐ Dementia

☐ Epilepsy, Date of last episode: _____ ☐ Head Injury ☐ Multiple Sclerosis

☐ Muscular Dystrophy ☐ Parkinson's Disease ☐ Stroke

☐ Seizure, Date of last episode: _____ ☐ Space-occupying Lesion (brain tumour), Date of last episode: _____

☐ Subarachnoid Haemorrhage, Date of last episode: _____

☐ Other (please specify): _____

8. PSYCHIATRIC CONDITION

Does your patient have a severe mental health/nervous condition? ☐ **No** ☐ **Yes**

If **Yes**, please tick the relevant condition(s):

☐ Post-Traumatic Stress Disorder (PTSD) ☐ Schizophrenia ☐ Personality Disorder

☐ Chronic Anxiety ☐ Chronic Depression

☐ Other: _____

Does your patient require medication? ☐ **No** ☐ **Yes**

If **Yes** - is your patient compliant with medication? ☐ No ☐ Yes

9. SLEEP DISORDER

Does your patient have a sleep disorder? ☐ **No** ☐ **Yes**

If **Yes**, please complete the following:

☐ Established Sleep Apnoea Syndrome ☐ Narcolepsy

Other: _____

10. SUBSTANCE MISUSE

Does your patient currently misuse alcohol or drugs? ☐ **No** ☐ **Yes**

If **Yes**, complete the following:

☐ Alcohol ☐ Illicit drugs ☐ Prescription drugs

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?

☐ Diplopia ☐ Monocular Vision ☐ Visual Field Defect ☐ 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?

☐ Cataracts ☐ Glaucoma ☐ Macular Degeneration

☐ 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? ☐ **No** ☐ **Yes**

Are glasses or contact lenses required for driving? ☐ **No** ☐ **Yes**

Should a condition be placed on the licence? ☐ **No** ☐ **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:

ADDITIONAL NOTES
Provide additional comment if required, to each Yes condition(s) below including reference to the specific condition (e.g. 4. Diabetes).

SECTION 5: MEDICAL PRACTITIONER'S DECLARATION

If you consider it prudent you may recommend that your patient undertakes a practical driving assessment. This is irrespective of your patient's age or driver's licence class.

Patients who hold a licence other than a "car" licence are required to undergo a practical driving assessment at age 85 and every year thereafter to retain the additional licence class.

If you consider that your patient may be unfit to drive, please immediately return the completed certificate to address given at the end.

It is recommended that you keep a copy of this form for your own records.

MEDICAL PRACTITIONER'S DECLARATION

On _____, I examined _____, _____
Date of Examination | Patient's Name | Date of Birth

This patient has been treated at this clinic for _____ years _____ months.

In my opinion the person who is the subject of this report:

Meets the relevant medical standard	☐ No	☐ Yes
Requires a practical driving test	☐ No	☐ Yes
Do you recommend conditions be placed on the licence?	☐ No	☐ Yes

Please provide further details on any of the above questions below:

_____

_____

_____

_____

☐ Further comments on medical condition(s) affecting safe driving are attached.

I certify that I personally examined the above-named patient in accordance with the "Assessing fitness to drive" guidelines.

Name: _____ Signature: _____ Date: _____

Medical Practitioner's practice address: _____

Telephone Number: _____ E-mail Address: _____

Please complete if a specialist has assessed any of the patient's conditions in addition to the treating medical practitioner (Not required if a separate report has been provided or a specialist has completed the declaration above). If more than one specialist has undertaken an assessment, please provide your details in the section above or attach a report if applicable.