PennState Health
Milton S. Hershey Medical Center

MEDICAL EVALUATION FOR DRIVING

Driver Evaluation and
Training Program

Penn State Health Milton S. Hershey Medical Center
Mail Code EC130
P.O. Box 859
Hershey, PA 17033-0859

Tel: (717) 531-7105
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(To be completed by client's doctor-PLEASE PRINT)

Name of Patient: _____

Address: _____

Diagnoses: _____

Date of Birth: _____ Phone: _____

☐ Male ☐ Female HMC Patient No. _____

Is the patient taking any medications with primary effects that might alter alertness, judgment, reaction time, or coordination?

Medication(s)	Possible Side Affect(s)
_____	_____
_____	_____
_____	_____

Does this patient have any of the following conditions or any other conditions that may affect the ability to safely operate a motor vehicle?

	No	Yes	
Seizure disorder	_____	_____	(date of last seizure, type of seizure, reliable aura) _____ _____
Cardiac precautions	_____	_____	(describe) _____ _____
Visual field cuts	_____	_____	(describe) _____ _____
Perceptual deficits	_____	_____	(describe) _____ _____
Periods of Dizziness/Vertigo	_____	_____	(describe) _____ _____

(PLEASE COMPLETE OTHER SIDE)

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	No	Yes	
Hearing deficits	_____	_____	(describe) _____
Cognitive deficits	_____	_____	(describe) _____
Impaired Judgment	_____	_____	(describe) _____
Substance abuse	_____	_____	(describe) _____
Diabetes	_____	_____	(describe) _____
Motor disorder	_____	_____	(describe) _____
Paralysis or weakness	_____	_____	(describe) _____
Lifting precautions	_____	_____	(describe) _____
Other conditions	_____	_____	(describe) _____

Should we be aware of any other conditions that may affect this individual's ability to operate a motor vehicle safely?

_____

_____

_____

Have you reported this individual to the Department of Transportation as being unable to drive? _____

Penn State Rehabilitation Center has my permission to conduct a driving evaluation on this patient to include an occupational therapy evaluation for cognitive, perceptual issues and/or behind the wheel assessment as deemed necessary by program personnel.

Physician's Signature:_____ Date:_____ Time:_____

MUST BE SIGNED BY A PHYSICIAN. PHYSICIAN'S ASSISTANT NOT ACCEPTABLE.

Physician's Name: _____ Phone: _____

Address: _____

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