TEXAS
Health and Human Services

Texas Department of State Health Services

Jennifer A. Shuford, MD, MPH
Commissioner

PLEASE USE THIS AS A COVER SHEET

PLEASE PROVIDE THIS LETTER WITH THE ATTACHED MEDICAL EVALUATION FORM TO BE COMPLETED BY YOUR PHYSICIAN

Dear Healthcare Provider:

The attached form has been brought to you by a candidate for, or current holder of, a Texas Driver's License. They have been referred by the Texas Department of Public Safety (DPS) to the Texas Department of State Health Services Medical Advisory Board **(DSHS MAB)** due to a concern about the candidate's medical history. The relevant section(s) pertaining to the candidate's referral MUST be **completely** filled out in order to process the referral.

If this is the first time you have seen this patient, please record what the patient states was their last occurrence of the reported medical issue. Additionally, please state this is the first time you have seen this patient, and this is the information that has been provided to you.

The Health and Safety Code authorizes the MAB to require the person to undergo a medical examination at his or her own expense. At this time, we are calling for a thorough and current medical evaluation, as it pertains to any medical limitations to driving. Current medical information is defined in Medical Advisory Board rules as being less than 12 months old. An examination will be necessary if one has not been conducted within 12 months. Please complete and return this MAB Medical Evaluation Form to the MAB at the following:

Email	Fax	Mail
dshsmab@dshs.texas.gov	**512-206-3778**	Texas Department of State Health Services ATTN: Medical Advisory Board (MC 1876) PO Box 149347 Austin, Texas 78714-9909

***For quickest response and processing times, we recommend emailing or faxing the completed paperwork.**

Health and Safety Code, Title 2 Subchapter H, Section 12.098, is the law pertaining to your liability protection, as it concerns any professional opinion, recommendation, or report you make for the purpose of assisting us in determining a candidate's ability to operate a motor vehicle.

Please note you are providing medical information and your professional medical opinion of this person's capability to drive.

If you have any questions about the forms or the procedure, please call (512) 834-6700 option 4.

Medical Advisory Board,
Texas Department of State Health Services.

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Medical Advisory Board (MAB) Medical Evaluation Form
(Required)

The Texas Department of Public Safety (DPS) has requested that the Medical Advisory Board (MAB) assist them in the evaluation of the case of:

Patient Information:	
Name:	
Date of Birth:	
Driver's License Number:	
Driver's license type - CDL (commercial) or DL	
Driver's license class - A, B, or C	
Email:	
Phone number:	
Signature giving the Medical Advisory Board Permission to contact physician for additional information.	

because of a concern about the candidate's medical history as it pertains to his/her license to operate a motor vehicle. Authority to perform this review is in accordance with the Transportation Code, Chapter 521, Section 321, the Health and Safety Code, Chapter 12, Sections 091 - 098, and the implementing rules adopted by the Texas Department of State Health Services.

Health and Safety Code, Title 2 Subchapter H, Section 12.098,

Is the law pertaining to your liability protection, as it concerns any professional opinion, recommendation, or report you make for the purpose of assisting us in determining a candidate's ability to operate a motor vehicle. (Excerpt below, visit our website Medical Advisory Board | Texas DSHS for full statue.) Health and Safety Code, Title 2, Subtitle A, Chapter 12, Subchapter H, Medical Advisory Board - Sec. 12.098. Liability.

Physician Information (Required):

Physician Name (Print)		
Physician Signature (MD/DO)		
DATE FORM COMPLETED:		
Physician License #		**Specialty:**
Business Address		
Phone Number		
******Medical forms completed by APP must be co-signed by Supervising Physician******		
Advanced Practice Provider Name		
Advanced Practice Provider Signature		
Advanced Practice Provider License #		
Advanced Practice Provider Phone		

Please note you are providing medical information and your professional medical opinion of this person's capability to drive, as you are physically evaluating the individual. Please read below for legal liability concerns.

Health and Safety Code, Title 2 Subchapter H, Section 12.098, is the law pertaining to your liability protection, as it concerns any professional opinion, recommendation, or report you make for the purpose of assisting us in determining a candidate's ability to operate a motor vehicle. (Excerpt below, visit our website Medical Advisory Board | Texas DSHS for full statue.) Added by Acts 1995, 74th Leg., Ch. 165, Sec. 9, eff. Sept. 1, 1995.

Health and Safety Code, Title 2 Subchapter H, Section 12.098,

Is the law pertaining to your liability protection, as it concerns any professional opinion, recommendation, or report you make for the purpose of assisting us in determining a candidate's ability to operate a motor vehicle. (Excerpt below, visit our website Medical Advisory Board | Texas DSHS for full statue.) Health and Safety Code, Title 2, Subtitle A, Chapter 12, Subchapter H, Medical Advisory Board - Sec. 12.098. Liability.

Texas Department of Public Safety
Medical Information Request

DL-177 (Rev. 1/2020)

Patient Information

Date | Patient's Name | Date of Birth | Driver License Number

Telephone Number | Email Address

Medical concern in question

What condition(s) is the patient being treated for?

Please provide last treatment/episode, if applicable.

Is patient currently prescribed any medication(s)? ☐ Yes ☐ No
If yes, please provide the medications and what they are prescribed for.

In your medical opinion, can the patient safely operate a motor vehicle? ☐ Yes ☐ No
If no, please explain:

Do you recommend that the department conduct a driving exam for further evaluation? ☐ Yes ☐ No

Physician's Information

Signature of Physician | Specialty | License Number

Telephone Number | Address | State

Mail or fax completed form to:

Texas Department of Public Safety
Attn: MAB
P.O. Box 4087
Austin, TX 78773

Fax: 512-424-5311

Email: MABquestions@dps.texas.gov

Patient Medical History (Required)

(Sections B-K are relevant for specific diagnoses/conditions.)

A. GENERAL PATIENT INFORMATION

(SECTION A IS REQUIRED: FAILURE TO COMPLETE WILL RESULT IN RETURN OF FORM)

1. **DATE OF EVALUATION: (Form must be filled out within 30 days of evaluation date)** _____
2. Condition(s) diagnoses the patient is being treated for with date of onset:`

   _____

   _____
3. Date of last episode: _____
4. List all current medications (include dose and frequency. If prn, average frequency of use) or attach med list

   _____

   _____

   _____
5. When did you start providing care for this patient? Date: _____
   a) Is this the first medical evaluation for this patient? Yes ☐ No ☐
   b) Did you review prior medical records/hospital records? Yes ☐ No ☐
   c) If No, then DO NOT COMPLETE this form until medical record review is verified
6. Date the patient was last examined/treated: _____
   a. Treatment provided: _____
7. In your opinion, can the patient safely operate a motor vehicle? Yes ☐ No ☐
   If no, please provide reason (MANDATORY)_____
8. Do you recommend a DPS driving evaluation? Yes ☐ No ☐
9. **Supporting Information (REQUIRED – CASE WILL NOT BE REVIEWED IF LEFT BLANK)**
   Please provide any additional information or specific comments regarding the patient's medical evaluation and capability for driving (include treatment plan, notes about condition stability and treatment compliance, ER and hospital visits related to above conditions – include ED/MD notes). Please include any recommendations or assurances related to driving (**or attach recent visit or progress notes**):

_____

_____

_____

_____

_____

_____

_____

Complete additional sections B-K which are relevant to your patient.

B. BLACKOUT	**NOT APPLICABLE ☐**
(UNEXPLAINED temporary loss of consciousness with no recall) OR, SYNCOPE (fainting) **Driver must be evaluated AFTER the mandatory syncope/blackout restriction period is completed**	
a) Single episode?	Yes ☐ No ☐
b) Multiple episodes?	Yes ☐ No ☐
If multiple, how many episodes in the last year?	
c) Date of episode (if single) or most recent episode	**Date:**
d) Cause of syncope:	
e) Vasovagal/aka Neurocardiogenic	Yes ☐ No ☐
f) Hypotensive (cause of hypotension if known)	Yes ☐ No ☐
g) Arrhythmia (complete relevant vascular section)	Yes ☐ No ☐
h) Diabetic episode? (complete relevant metabolic section)	Yes ☐ No ☐
i) Neurological cause? (complete relevant neurological section)	Yes ☐ No ☐
j) Substance related? (complete relevant substance abuse section)	Yes ☐ No ☐
k) Other (cause if known)	Yes ☐ No ☐
l) Unknown - provide documentation of any evaluation: (general, cardiac, neuro and fill out relevant section)	
m) In your opinion, is the condition controlled?	Yes ☐ No ☐

C. BREATHING RELATED CONDITIONS		**NOT APPLICABLE ☐**
1)	Does the patient have asthma?	Yes ☐ No ☐
2)	Does the patient have COPD?	Yes ☐ No ☐
3)	Dyspnea?	
	☐ No	
	☐ Yes, at rest	
	☐ **Yes, with exertion with O2 sat > 88% without supplemental O2**	
	☐ **Yes, with exertion with O2 sat> 88% with supplemental O2**	
	☐ **Yes, with exertion and O2 sat< 88% even with supplemental O2**	

D. DISORDERS OF SLEEP/ALERTNESS		**NOT APPLICABLE ☐**
1)	Does the patient have sleep apnea?	Yes ☐ No ☐
	If Yes (required)	
	What was the AHI (Apnea-Hypopnea Index) prior to treatment?	**AHI** **DATE:**
	What is the AHI score on treatment? What treatment is patient using?	**AHI** **DATE:**
	Is the patient compliant with treatment? Verified by CPAP data download at least annually. Commercial License A&B require satisfactory score on Maintenance Wakefulness Test Has the patient had a MVA due to excessive drowsiness?	Yes ☐ No ☐ **SCORE:**_____ **DATE:**_____
2)	Does the patient have Narcolepsy?	Yes ☐ No ☐
	If Yes	
	Does the patient have cataplexy? Yes ☐ No ☐	
	Is the patient compliant with medication?	Yes ☐ No ☐
	Does the patient have uncontrolled daytime sleepiness or sleep attacks?	Yes ☐ No ☐
	If Yes, What is the frequency of the attacks and what was the date of the last attack? Has Maintenance of Wakefulness Test been performed? Yes ☐ No ☐ Has the patient had a MVA due to excessive drowsiness?	Frequency: _____ **Score:**_____ Date:_____
3)	Does the patient have Shift Work Sleep Disorder?	Yes ☐ No ☐
	What treatment is the patient using?	
	Is the patient compliant with treatment?	Yes ☐ No ☐
	Has the patient had a MVA due to excessive drowsiness?	Yes ☐ No ☐

E. VASCULAR DISEASE *(To be completed by cardiology)*		**NOT APPLICABLE ☐**
1)	Cardiovascular Disease/Heart Failure-Functional Classification American Heart Association (AHA) ☐ AHA Class I — AHA Class I: No symptoms ☐ AHA Class II — AHA Class II: Symptoms with strenuous activity ☐ AHA Class III — AHA Class III: Symptoms with normal activity ☐ AHA Class IV — Class IV: Symptoms at rest	
2)	**Cardiovascular Disease/Heart Failure – Objective medical classification:** ☐ Class A - No objective evidence of cardiovascular disease ☐ Class B - Objective evidence of minimal cardiovascular disease ☐ Class C - Objective evidence of moderately severe cardiovascular disease ☐ Class D - Objective evidence of severe cardiovascular disease	
3)	Blood pressure: _____ Heart Rate: _____	
4)	**Angina Pectoralis:** ☐ At rest or with minimal exertion ☐ With mild exertion (walking 1-2 blocks, climbing 1 flight of stairs) ☐ With moderate exertion ☐ With severe exertion	
5)	**Malignant hypertension or hypertensive urgency:**	Yes ☐ No ☐

E. VASCULAR DISEASE		***continued...***
6)	**Coronary Artery Disease/Myocardial Infarction/D.V.T.** 1) Yes ☐ No ☐ Myocardial Infarction Date: 2) Yes ☐ No ☐ DVT Date: 3) Yes ☐ No ☐ Bypass grafting Date: 4) Yes ☐ No ☐ Stenting Date: 5) **Cleared to drive?** By PCP? **Yes ☐ No ☐** (for drivers with Class C driver license) By Cardiology? **Yes ☐ No ☐ (REQUIRED for drivers with Commercial driver license Class A & B**) 6) **Stable?** **Yes ☐ No ☐** On antiplatelet agents **Yes ☐ No ☐** On anticoagulants **Yes ☐ No ☐**	
7)	**Arrythmias:**	
	a) Syncopal episode(s) associated with cardiac condition If Yes, Date:_____	Yes ☐ No ☐
	b) Atrial fibrillation/flutter	Yes ☐ No ☐
	Under treatment by cardiology	Yes ☐ No ☐
	Heart Rate is controlled	Yes ☐ No ☐
	On stable anticoagulation	Yes ☐ No ☐
	c) Av nodal re-entry tachycardia	**Yes ☐ No ☐**
	Symptomatic	Yes ☐ No ☐
	Not symptomatic OR controlled with catheter ablation or medial therapy	Yes ☐ No ☐
	d) Wolff Parkinson White syndrome	**Yes ☐ No ☐**
	With atrial fibrillation	Yes ☐ No ☐
	Without atrial fibrillation	Yes ☐ No ☐
	e) Ventricular tachycardia	**Yes ☐ No ☐**
	History of sustained V tach	Yes ☐ No ☐
	Non-sustained V tach	Yes ☐ No ☐
	Controlled with medication	Yes ☐ No ☐
	Date of tachycardia control _____	
	f) Other Arrythmias - Specific type:	
	g) Has Pacemaker been placed Has AICD (defibrillator) been placed Date of Placement: _____	Yes ☐ No ☐ Yes ☐ No ☐
8)	**Heart block- if applicable Check one** ☐ First Degree ☐ Second degree Mobitz I ☐ Second degree Mobitz II ☐ Third degree	
9)	**Commercial Drivers Only:** Has the patient completed Stage II of the standard Bruce protocol (treadmill test) within the last year? **(Required: ATTACH TEST RESULTS)**	**Yes ☐ No ☐**

F. NEUROLOGICAL		**NOT APPLICABLE ☐**
1)	**TIA**	
	a) Single episode?	Yes ☐ No ☐
	Multiple episodes?	Yes ☐ No ☐
	If multiple, how many TIAs in the last year?	
	Date of most recent TIA: _____	
	Stable on antiplatelet or anticoagulant therapy?	Yes ☐ No ☐
2)	**CVA/Stroke** **Date of stroke:** _____	
	a) Residual Deficits ☐ None ☐ Mild: Able to control driving equipment as assessed by MD, Rehab or DPS Driving Evaluation ☐ Moderate : Motor Strength (4/5) or coordination impaired. ☐ Severe	
	b) If moderate to severe, describe deficit(s):	
	c) Any visual deficits? If yes, complete visual evaluation by Ophthalmology	Yes ☐ No ☐
	d) Any language deficits: If yes, requires Neurologist evaluation. Describe:	Yes ☐ No ☐
3)	**Seizures** **Driver must be evaluated AFTER the mandatory seizure restriction period is completed**	
	a) Date of last seizure: _____	
	b) Total number of seizures in the last 12 months: _____	
	c) On antiseizure medications?	Yes ☐ No ☐
	d) The patient reliably takes his/her antiseizure medication ?	Yes ☐ No ☐
	e) Any medication side effects which might interfere with driving? If yes, what side effects?	Yes ☐ No ☐
	f) fDoes the patient avoid alcohol use, psychoactive drugs, sleep deprivation and extreme fatigue?	Yes ☐ No ☐
	g) Does the patient have an RNS, VNS or DBS for seizure treatment?	Yes ☐ No ☐
	h) Has the patient had motor vehicle accident (MVA) in the last five years due to seizure? Dates:	Yes ☐ No ☐
4)	**Cognitive impairment/Dementia**	
	a) MMSE____, SLUMS____ or MoCA____ score (in the last 3 months-required) Check test performed	Score_____ Date:_____
	b) Has the patient passed a professional/Rehab evaluation for driver safety? If yes, supply the report	Yes ☐ No ☐
	c) Does family or caregiver feel patient is safe to drive?	Yes ☐ No ☐
	d) Has patient had MVA or traffic citations in the last 2 years?	Yes ☐ No ☐
	e) Does patient exhibit impaired judgement impulsivity, or aggression?	Yes ☐ No ☐

F. NEUROLOGICAL	***continued...***
5)	**Vertigo/Dizziness** Severity (Check one): ☐ Mild (acute episodic vertigo, stable on medication) ☐ Moderate (Benign positional vertigo, acute/chronic vestibulopathy) ☐ Severe (Meniere's Disease, nonfunctioning labyrinths)
6)	**Other Neurologic Disorders: Traumatic Brain Injury, Movement Disorders, Multiple Sclerosis, Peripheral Neuropathy** **If the condition is associated with cognitive impairment, complete Cognitive Impairment (Section 4) above**
	a) Diagnosis:
	b) Severity (Check one): ☐ Mild cognitive, visual, sensorimotor or coordination deficits; independent with ADL's ☐ Moderate neurological deficits but independent with ADL's ☐ Severe neurological deficits; not independent with ADL's
7)	**Parkinson's Disease**: Date of Parkinsons Diagnosis: _____ Severity (Check one – must be completed by Neurologist): ☐ Mild (Tremor, stiffness, slowing of gait/cognition independent with ADL) ☐ Moderate (Tremor, speech affected, motor fluctuations, imbalance, falls, independent with ADL's) ☐ Severe (Rigidity, falls, severe motor fluctuations, not independent with ADL's)

G. PSYCHIATRIC		**NOT APPLICABLE ☐**
a)	**Diagnosis:** ----------	
b)	**At the time of this evaluation, is the patient:**	
	Aggressive, assaultive, or excessively hostile?	Yes ☐ No ☐
	Experiencing hallucinations or delusions?	Yes ☐ No ☐
	Homicidal?	Yes ☐ No ☐
	Suicidal?	Yes ☐ No ☐
	Impulsive?	Yes ☐ No ☐
	Paranoid?	Yes ☐ No ☐
	Exhibiting impaired judgement?	Yes ☐ No ☐
c)	Is the patient compliant with medication/ treatment?	Yes ☐ No ☐
d)	Do medications cause any drowsiness or adverse effects that would impair driving?	Yes ☐ No ☐
e)	**In your opinion, is the psychiatric condition adequately controlled?**	Yes ☐ No ☐

H. ALCOHOL AND DRUG USE/ABUSE		**NOT APPLICABLE ☐**
a)	Substance used or abused:	
b)	Length of use/dependency:	
c)	Last known use:	
d)	Any history of DWI:	Yes ☐ No ☐ **# of convictions?** _____
e)	Number of times treated:	
f)	Month/year of last treatment:	
g)	Member of AA/NA or other social support organization:	Yes ☐ No ☐ **(ATTACH SUPPORTING DOCUMENTS/CERTIFICATES)**
h)	On Naloxone/Antabuse/Disulfiram:	Yes ☐ No ☐
i)	On Methadone/Suboxone:	Yes ☐ No ☐
j)	Urine drug screen ***(required for history of drug use)*** **ATTACH RESULTS**	**Yes ☐ No ☐**
k)	**Phosphatidyl ethanol (PEth) blood test: *(required for history of alcohol abuse)*** ***Urinalysis no longer accepted*** **-- ATTACH RESULTS**	**Yes ☐ No ☐**

If 3 or more DWI – Complete Neurology and Psychiatric sections

I. METABOLIC DISEASE		**NOT APPLICABLE ☐**
a)	**Chronic severe or end stage renal failure**	**Yes ☐ No ☐**
	If yes, compliant with medical therapy/dialysis? _____	
b)	**Diabetes**	**Yes ☐ No ☐**
	On oral agents	Yes ☐ No ☐
	On insulin	Yes ☐ No ☐
	HgbA1c:_____	
c)	Any episodes of DKA, coma, shock, or symptomatic hypoglycemia	Yes ☐ No ☐
d)	Number of incidents in the last year: _____	
e)	Any incidents require hospitalization	Yes ☐ No ☐
f)	Is the patient compliant with therapy?	Yes ☐ No ☐
g)	Does the patient have a Continuous Glucose Monitor (CGM)	Yes ☐ No ☐
h)	Does the patient have any issues with neuropathy due to diabetes?	Yes ☐ No ☐
i)	Does the patient have any visual deficits due to the diabetes? If Yes, (Complete section **K** below)	Yes ☐ No ☐

J. MUSCULOSKELETAL		**NOT APPLICABLE ☐**
a)	Any functional impairment of upper or lower extremities (arthritis, weakness, spasticity)?	Yes ☐ No ☐
	If yes, specify condition and describe impairment:	
b)	Is the condition progressive?	Yes ☐ No ☐
c)	Is assistive equipment employed?	Yes ☐ No ☐
d)	**If so, is the equipment effective in allaying functional impairment?**	**Yes ☐ No ☐**

K. VISION *(Must be completed by ophthalmology or optometry)*				**NOT APPLICABLE ☐**
a)	**Cause of visual impairment:** _____			
b)	**Visual acuity:**			
	Without correction:	R 20/_____	L 20/_____	
	With present correction:	R 20/_____	L 20/_____	
	With best correction:	R 20/_____	L 20/_____	
c)	Does the patient use a biopic telescope?			Yes ☐ No ☐
	If yes,			
	Type of biopic telescope? _____			
	Power of telescope? _____			
	Visual acuity with telescope	R 20/_____	L 20/_____	
d)	Does the patient have diplopia?			Yes ☐ No ☐
	If yes, is the diplopia constant?			Yes ☐ No ☐
e)	Is the diplopia monocular?			Yes ☐ No ☐
	If yes, which eye? _____			
f)	Is the diplopia correctable with a patch?			Yes ☐ No ☐
g)	Does the patient have a visual field impairment?			Yes ☐ No ☐
	If yes, describe type and degree of field loss (ATTACH visual field test results):			