DEPARTMENT OF TRANSPORTATION
DRIVER AND MOTOR VEHICLE SERVICES
1905 LANA AVE NE, SALEM OREGON 97314

MANDATORY IMPAIRMENT REFERRAL

(OAR CHAPTER 735 DIVISION 74)

Clear Form

Print

This report and all attached or related Medical information complies with HIPAA, is confidential outside of a court order or administrative hearing, and is used only to determine the qualifications of the person to safely operate motor vehicles.

REQUIRED

PATIENT LAST NAME *(please print)*	FIRST NAME	MIDDLE NAME	SEX	DATE OF BIRTH (MM/DD/YYYY)
			○M ○F ○X	

RESIDENCE ADDRESS	CITY	STATE	ZIP CODE	COUNTY

Date of most recent clinical contact: _____ *(See Instructions, #2 below)*

Underlying medical condition or diagnosis: _____ **is** ☐ Chronic ☐ Progressive

This patient is over 14 years of age and the impairment(s) described below are based on clinical contact.

Submission of this form may result in an immediate suspension of the patient's driving privileges.

FUNCTIONAL IMPAIRMENTS with descriptions *(OAR 735-074-0130(1), (2))*

REQUIRED *(mark all that apply)*

Vision – Patient is unable to meet the state vision standards *(below)*, even with correction:

☐ **Acuity** – Patient's acuity is worse than 20/70 in the best eye.

☐ **Horizontal field** of vision – Patient's field of vision is less than 110 degrees.

Peripheral Sensation

☐ Inability to firmly grasp, manipulate, operate and release primary and secondary driving controls resulting in momentary loss of control of the vehicle, in improper or delayed signal to other drivers that the vehicle is turning, changing lanes or stopping, or difficulty stopping the vehicle;

☐ Difficulty gripping the steering wheel resulting in loss of ability to control the vehicle's lane position and turning motion;

☐ Difficulty using foot controls effectively resulting in improper or delayed signal to other drivers that the vehicle is slowing or stopping, or difficulty stopping the vehicle.

Strength

☐ Inability to consistently maintain a firm grip on objects.

☐ Inability to apply consistent pressure to objects with legs and feet.

☐ Weakness or paralysis of muscles affecting the ability to maintain sitting balance.

☐ Weakness or paralysis in extremities affecting the ability to feel, grasp, manipulate or release objects or use foot controls effectively.

Flexibility

☐ Rigidity and/or limited range of mobility in neck, torso, arms, legs or joints.

Motor Planning & Coordination

☐ Difficulty and slowness in initiating movement.

☐ Vertigo, dizziness, loss of balance or other motor planning conditions.

☐ Involuntary muscle movements.

☐ Loss of muscle control.

Other

☐ *Describe on next page or on an attachment.*

COGNITIVE IMPAIRMENTS with descriptions *(OAR 735-074-0130(3))*

REQUIRED *(mark all that apply)*

Attention

☐ Decreased awareness.

☐ Reduced ability to efficiently switch attention between multiple objects.

☐ Reduced processing speed.

Judgment & Problem Solving

☐ Reduced processing speed.

☐ Inability to understand a cause and effect relationship.

☐ Deficit(s) in decision-making ability.

Reaction Time

☐ Delayed reaction time.

Planning & Sequencing

☐ Deficit(s) in the ability to anticipate and/or react to changes in the environment.

☐ Problems with sequencing activities.

Impulsivity

☐ Lack of emotional control.

☐ Lack of decision-making skills.

Email, FAX or Mail: Instructions, next page or reverse

(continued)

REQUIRED *(mark all that apply)*

Visuospatial	☐ Problems determining spatial relationships.	
Memory	☐ Problems with confusion and/or memory loss. ☐ Decreased working memory capacity.	
Loss of Consciousness or Control	☐ Single recent episode	Date of Last Episode: _____
	☐ Multiple recent episodes	Date of Last Episode: _____
	☐ Medication to prevent recurrence:	_____
Other	☐ *Describe below*	

Describe how the impairments marked above affect the patient's ability to drive safely. Please provide relevant supporting information, such as: chart notes; pertinent test results; medications which may interfere with safe driving behaviors; recorded visual acuities, vision field maps; effects of problem intoxicant use (drug, alcohol, inhalant use), etc. Provider memos or letters may also be included.

REQUIRED

I am a mandatory reporter, as described below:

- ☐ The patient's **Primary Care Provider** *(including Hospitalists while receiving in-patient care)*
- ☐ A **physician, physician associate, or nurse practitioner** providing specialist evaluation or ongoing care based on a referral from the patient's primary care provider ***related to a cognitive or functional impairment***.
- ☐ A **health care provider*** providing health care services based on a referral from the person's primary care provider ***related to a cognitive or functional impairment*** *(see definition, below).*
- ☐ A **physician or health care provider*** providing emergency healthcare services.

REQUIRED

REPORTER'S NAME *(Required - please print)*	SPECIALTY	PROFESSIONAL LICENSE or CERTIFICATE # *(Required)*	
MAILING ADDRESS	FAX #	TELEPHONE # (and EXT.)	
CITY	COUNTY	STATE	ZIP CODE
REPORTER SIGNATURE X		DATE SIGNED *(Required)*	

DEFINITIONS

***Health care provider** - a person licensed, certified or otherwise authorized or permitted by law to administer health care in the State of Oregon. Specifically, for purposes of these rules, a health care provider is limited to: a chiropractic physician, nurse practitioner, occupational therapist, physical therapist, optometrist, physician assistant, podiatric physician or surgeon and a mental health provider.

Severe – the impairment substantially limits a person's ability to perform Instrumental Activities of Daily Living, including driving. It does not include a temporary impairment not expected to last more than six months.

Uncontrollable – the impairment persists ***despite efforts to control or compensate*** for it by medication, therapy, surgery, or adaptive devices. It ***does not include*** a temporary impairment currently being treated and not expected to last more than six months.

INSTRUCTIONS

1. Complete all sections above. Attach any additional information which can assist DMV's Medical Determination Officer in assessing a patient's ability to drive safely.
2. Include relevant diagnostics, progress notes, etc. (*ORS 807.710, OAR 735-074-0070*) **When an impaired vision report**, please include recorded visual acuities and the results of the visual fields that prompted the referral.
3. **Sign and date.** The report ***cannot*** be processed without it.
4. **Email, FAX or mail** completed forms and any relevant medical information on the patient to DMV - DRIVER SPECIALTY SERVICES:

   EMAIL: **DMVDriverSafetyTeam@odot.oregon.gov**

   FAX: **(503) 945-5329**

   MAIL: **1905 LANA AVE NE**
   SALEM, OR 97314-4120

5. **Call to verify receipt**: (503) 945-5083 or TTY: (503) 945-5001