FLORIDA DEPARTMENT OF HIGHWAY SAFETY AND MOTOR VEHICLES
Medical/Re-Exam Referral Form

This form is completed by examiners/agents to document observations and/or admissions by the customer concerning issues that may affect the customer's ability to safely operate a motor vehicle.

Customer Information

Name of Customer _____ DOB _____ Sex _____

Address _____ Telephone Number _____

Driver License Number _____ State _____ Type _____

Source of Information

A. Driver License Application

Examiner Name _____ Office Telephone Number _____

B. Informant / Written Complaint

Name of Informant _____ Relationship to Customer _____

Address of Informant _____ Telephone Number _____

Observations / Admissions

A. Customer's Admissions

☐ Progressive Neurological Disorder ☐ Alzheimer's Disease ☐ Epilepsy

☐ Fainting ☐ Dizzy Spells ☐ Alcohol/drug addiction within past 2 years

Treating Physician Name _____ Telephone Number _____

B. Examiner/Agent Observations

☐ Difficulty with Mobility ☐ Lack of Comprehension or Orientation

☐ Hearing or Visual ☐ Difficulty Responding to Questions Due to Memory or Confusion

☐ Violent or Aggressive Behavior ☐ Weakness or Coordination Problems

☐ Other

Please Explain Any Area That Was Marked: _____

_____

_____

Recommendation

☐ 5 Day Letter
- Complete the Five-Day Letter.
- Retain documents in the issuing office for one year. They do not need to be sent to Medical Review Program.

☐ Forward to Medical
- Mail or fax the completed form to Division of Motorist Services, Attention: Medical Review Program, Room A227, Neil Kirkman Building, Tallahassee, Florida 32399-0570, Fax (850) 617-3944.

_____ _____

Signature of Examiner/Agent User ID Date *Signature of Supervisor/Manager User ID Date*

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Office Address Office Number