

## **Basic Fatigue Management Medical Certificate Process**

### **Information for the driver / applicant (ASSESSING FITNESS TO DRIVE 2016)**

#### **Driver Health Questionnaire (Pages 2 – 5)**

The *Driver Health Questionnaire* is a screening tool to help identify conditions that might affect a person's capacity to drive safely. It is completed by the driver prior to the health assessment.

The questionnaire is not a diagnostic tool and no decision can be made regarding the person's fitness to drive until a full clinical examination is performed.

The examining doctor will need to review the answers with the applicant to ascertain relevant details and guide the clinical examination, including the conduct of additional tests.

Dishonest completion of the questionnaire may be an issue. Drivers are required to sign the completed questionnaire in the presence of the examining doctor as a declaration of the completeness and accuracy of the information. The doctor then countersigns. If the driver refuses to sign, the examination should not proceed.

The driver will also sign the declaration regarding disclosure of information to acknowledge that they understand and agree with how their health information will be used.

The form should be retained by the doctor and filed in the driver's medical record. For privacy reasons, it should not be returned to the requesting organisation, if there is one.

#### **Information for the examining doctor**

##### **Clinical Assessment Record (Pages 6 – 8)**

The *Clinical Assessment Record* is a tool to guide the health assessment process. It provides a standard format for recording the results of the assessment and the reasons for the fitness to drive conclusions.

The doctor records the results of the assessment and retains the form (Pages 2 to 8) in the driver's confidential medical record. The doctor may give a full copy of the report back to the patient.

The assessment is to be conducted in accordance with the Austroads "Assessing Fitness to Drive – 2016" standards, a copy of the standards are available on the Austroads website ([www.austroads.com.au](http://www.austroads.com.au))

##### **Basic Fatigue Management – Fitness to Drive Report (Page 9)**

The doctor will then summarise the results in terms of the driver meeting the medical criteria on the *Fitness to Drive Report* form (Page 9). This page is required to be provided to the patient's employer.

For privacy reasons, the completed *Clinical Assessment Record* must not be forwarded to the requesting organisation, if there is one.



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Assessing Fitness to Drive 2016  
**Health Assessment for Commercial Vehicle Driver**

**DRIVER HEALTH QUESTIONNAIRE**  
(to be completed by driver and provided to the examining doctor)

**Driver information:**

Surname:	Given name(s):
Address:	
Date of birth:	Phone:
Driver licence number:	State of issue:

**Employer information:**

Employer name:	
Address:	Phone:

**Instructions for completion:**

Please answer the questions by ticking the appropriate box. If you are not sure what a question means, leave the answer blank and the health professional will help you. The health professional will ask you additional questions during the assessment. On completion of the questionnaire you will be asked to sign a declaration to confirm the accuracy of your responses.

Please bring with you to the assessment:

- A list of current prescription, non-prescription and complementary medicines
- Glasses/contact lenses and hearing aids if you use them
- Disease management plans (e.g. sleep disorder management plan, diabetes management plan)

**Disclosure of health information:**

**Please read carefully and sign to indicate you understand how health information is reported, stored and accessed.**

The details of your health assessment will remain confidential and will only be reported to the requesting organisation in terms of whether you meet the medical criteria for driving a commercial vehicle. The examining health professional retains all detailed health documentation including your questionnaire responses and the completed record of clinical findings. The examining health professional will provide you with the report form to return to the requesting organisation indicating your fitness for duty classification. Other than the above, your personal information will not be disclosed to any other person or organisation without your written permission, except when required by law.

You have the right to access your health records including those held by the examining health professional and the reports held by the requesting organisation.

**Driver's declaration**

I have read and understood the above statement concerning the health information provided in this document.

Signature of driver

Date

**Consent to contact treating health professionals**

I consent to the examining doctor contacting my treating health professionals to clarify aspects of my medical management.

Signature of driver

Date

## Questions:

1. Are you currently attending a health professional for any illness, injury or disability?  No  Yes
2. Are you taking any prescription, non-prescription or complementary medicines?  No  Yes

If YES to Question 1 or 2 please provide brief details:

Health professional's comments:

### 3. Do you suffer from or have you ever suffered from any of the following:

3.1	High blood pressure	<input type="checkbox"/> No <input type="checkbox"/> Yes	3.11	Stroke	<input type="checkbox"/> No <input type="checkbox"/> Yes
3.2	Heart disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	3.12	Dizziness, vertigo, problems with balance	<input type="checkbox"/> No <input type="checkbox"/> Yes
3.3	Chest pain, angina	<input type="checkbox"/> No <input type="checkbox"/> Yes	3.13	Memory loss or difficulty with attention or concentration	<input type="checkbox"/> No <input type="checkbox"/> Yes
3.4	Any condition requiring heart surgery	<input type="checkbox"/> No <input type="checkbox"/> Yes	3.14	Other neurological disorder	<input type="checkbox"/> No <input type="checkbox"/> Yes
3.5	Palpitations / irregular heartbeat	<input type="checkbox"/> No <input type="checkbox"/> Yes	3.15	Neck, back or limb disorders	<input type="checkbox"/> No <input type="checkbox"/> Yes
3.6	Abnormal shortness of breath	<input type="checkbox"/> No <input type="checkbox"/> Yes	3.16	Double vision, difficulty seeing	<input type="checkbox"/> No <input type="checkbox"/> Yes
3.7	Diabetes	<input type="checkbox"/> No <input type="checkbox"/> Yes	3.17	Colour blindness	<input type="checkbox"/> No <input type="checkbox"/> Yes
3.8	Head injury, spinal injury	<input type="checkbox"/> No <input type="checkbox"/> Yes	3.18	Hearing loss or deafness or had an ear operation or use a hearing aid	<input type="checkbox"/> No <input type="checkbox"/> Yes
3.9	Seizures, fits, convulsions, epilepsy	<input type="checkbox"/> No <input type="checkbox"/> Yes	3.19	A psychiatric illness or nervous disorder	<input type="checkbox"/> No <input type="checkbox"/> Yes
3.10	Blackouts or fainting	<input type="checkbox"/> No <input type="checkbox"/> Yes			

Health professional's comments:

4. Have you ever had any other serious injury, illness, disability, operation or accident or been in hospital for any reason? (please describe).  No  Yes

Health professional's comments:

### 5. Sleep

5.1	Have you ever been tested for a sleep disorder or been told by a doctor that you have a sleep disorder, sleep apnoea or narcolepsy?	<input type="checkbox"/> No <input type="checkbox"/> Yes
5.2	Has anyone told you that your breathing stops or is disrupted by episodes of choking during your sleep?	<input type="checkbox"/> No <input type="checkbox"/> Yes

5.3	How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? <i>This refers to your usual way of life in recent times. If you haven't done some of these things recently try to work out how they would have affected you.</i>	would never doze off <b>(0)</b>	slight chance of dozing <b>(1)</b>	moderate chance of dozing <b>(2)</b>	high chance of dozing <b>(3)</b>
a	Sitting and reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b	Watching TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c	Sitting inactive in a public place (e.g. a theatre or a meeting)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d	As a passenger in a car for an hour without a break	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e	Lying down to rest in the afternoon when circumstances permit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f	Sitting and talking to someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g	Sitting quietly after a lunch without alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h	In a car, while stopped for a few minutes in the traffic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Health professional's comments:**

## 6. Alcohol

6.1 Have you ever sought assistance for alcohol or substance use issues?  No  Yes

6.2 Please circle the answer that best describes your situation.

	<b>(0)</b>	<b>(1)</b>	<b>(2)</b>	<b>(3)</b>	<b>(4)</b>	
a	How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times per month	2 to 3 times per week	4 or more times per week
b	How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 to 5	5 to 6	7 to 9	10 or more
c	How often do you have six or more drinks on one occasion?	Never	Monthly or less	2 to 4 times per month	2-3 times per week	>3 times per week
d	How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Monthly or less	2 to 4 times per month	2-3 times per week	>3 times per week
e	How often during the last year have you failed to do what was normally expected from you because of drinking?	Never	Monthly or less	2 to 4 times per month	2-3 times per week	>3 times per week
f	How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Monthly or less	2 to 4 times per month	2-3 times per week	>3 times per week
g	How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Monthly or less	2 to 4 times per month	2-3 times per week	>3 times per week
h	How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Monthly or less	2 to 4 times per month	2-3 times per week	>3 times per week
i	Have you or someone else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year
j	Has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year

**Health professional's comments**

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**Other**

7. Do you currently use illicit drugs?  No  Yes
8. Do you use any drugs or medications not prescribed for you by your doctor?  No  Yes
9. Have you been in a vehicle crash since your last fitness to drive examination?  No  Yes

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**Health professional's comments**

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**Driver's declaration – accuracy and completeness of information provided**

To the best of my knowledge the answers given above are accurate and complete:

Signature of driver

Date

Signature of examining doctor

Date

# CLINICAL ASSESSMENT RECORD

IN-CONFIDENCE WHEN COMPLETED

PAGES 2 – 8 SHOULD BE RETAINED BY THE HEALTH PROFESSIONAL

## Driver information:

Surname:	Given name(s):
Address:	
Date of birth:	Phone:
Driver licence number:	State of issue:

## Employer information:

Employer name:	
Address:	Phone:

## Nature of driving duties:

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## CLINICAL ASSESSMENT:

### 1. Vision

#### 1.1 Visual acuity (refer AFTD, page 124, 129)

Are glasses or contact lenses worn?  Yes  No

	R	L	Both
Without Correction	6 /	6 /	6 /
With Correction	6 /	6 /	6 /

Meets criteria  Without correction  With correction

Does not meet criteria

#### 1.2 Visual Fields Normal Abnormal (refer AFTD, page 125-26, 128)

#### Comments:

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### 2. Hearing (refer AFTD, page 67-69 including flowchart)

Assess clinically in the first instance. Audiometry is only required if clinical assessment indicates possible hearing loss. (Clinical tests used to screen for hearing impairment include testing whether a person can hear a whispered voice, a finger rub, or a watch tick at a specific distance. Perceived hearing loss can be assessed by asking a single question (for example, "Do you have difficulty with your hearing?" as per the Driver Health Questionnaire)

Possible hearing loss?  Yes  No

If yes, are hearing aids worn?  Yes  No

Refer for audiometry if indicated:

	Hearing level at frequencies (db)							Average of	
	0.5kHz	1.0kHz	1.5kHz	2.0kHz	3.0kHz	4.0kHz	6.0kHz	8.0kHz	0.5,1,2,3 kHz
Right ear									
Left ear									

Meets criteria  Without hearing aid  With hearing aid

Does not meet criteria

Comments:
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**3. Cardiovascular system** (refer AFTD page 39-58)

Relevant findings from questionnaire:

<b>Blood pressure</b>	Repeated (if necessary)
Systolic	Systolic
Diastolic	Diastolic

Pulse rate      beats/min     Normal     Abnormal

Heart sounds                       Normal     Abnormal

Peripheral pulses                 Normal     Abnormal

Comments (including comments regarding overall cardiac risk and risk factors e.g. obesity, smoking, exercise, stress):

**4. Diabetes** (Refer AFTD page 59-66)

Existing diabetes?                 No         Yes

Comments:

**5. Musculoskeletal / neurological system**

(Refer AFTD page 71-75, 76-105)

Comments include relevant findings from questionnaire including existing neurological and musculoskeletal conditions:

Cervical spine rotation             Normal     Abnormal

Back movement                       Normal     Abnormal

Upper limbs: (a) Appearance       Normal     Abnormal

(b) Joint movements                 Normal     Abnormal

Lower limbs: (a) Appearance       Normal     Abnormal

(b) Joint movements                 Normal     Abnormal

Reflexes                                 Normal     Abnormal

Romberg's sign\*                       Normal     Abnormal

(\* A pass requires the ability to maintain balance while standing with shoes off, feet together side by side, eyes closed and arms by sides, for thirty seconds)

Functional/ practical assessment required?

No         Yes

Comments:

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**6. Psychological health** (Refer AFTD page 107-110)

Relevant findings from questionnaire:

**Mental state examination:**

Appearance .....  Normal         Abnormal

Attitude.....  Normal         Abnormal

Behaviour.....  Normal         Abnormal

Mood and affect.....  Normal         Abnormal

Thought form stream and content.....  Normal         Abnormal

Perception.....  Normal         Abnormal

Cognition.....  Normal         Abnormal

Insight.....  Normal         Abnormal

Judgement.....  Normal         Abnormal

Comments:

**7. Sleep disorders** (Refer AFTD page 112-115)

Existing sleep disorder?             No         Yes

**ESS Score (Screen):**

(Q 5 of Driver Health Questionnaire)

(Score > 16 is consistent with moderate to severe excessive daytime sleepiness. Do not rely solely on the ESS to rule out sleep apnoea)

Clinical signs of sleep disorder     Absent         Present

Comments:

**8. Substance misuse** (Refer AFTD page 117 -121)

Note: Drug screening not routinely required.

Existing substance use disorder?     No         Yes

**Audit Score (Screen):**

(Q6 of Driver Health Questionnaire)

(Score > 8 indicates strong likelihood of hazardous or harmful alcohol consumption)

Clinical signs of substance misuse     Absent         Present

Comments:

**9. Medication**

Specify:

## SUMMARY

### Summarise significant findings

Are any further investigations or referrals required?  Yes (describe) No

### What is the recommendation for this driver in terms of fitness to drive?

- Unconditionally** meets the medical criteria – meets all relevant medical criteria (no restrictions)
- Conditionally** meets the medical criteria for fitness to drive – has a medical condition that may impact on fitness to drive but it is well controlled and meets the conditional criteria in *Assessing Fitness to Drive 2016*. Indicate also if:

- Driver requires aids to drive:

Vision aids  Hearing aids  Other devices or vehicle modifications (specify)

- Driver requires more frequent review than prescribed under normal periodic review:

Specify recommended review:

- Temporarily** does not meet the medical criteria (unconditional or conditional) – pending further investigation and treatment (record details).

- Permanently** does not meet the medical criteria (record details)

### Contact(s) with other treating health professional(s)

Note: Contact is to be made with patient's consent as per questionnaire

### Contact with requesting organisation (if relevant and clinically warranted)

- If the driver is classified *Temporarily* or *Permanently* does not meet the medical criteria, send Fitness to Drive Report immediately to requesting organisation, if relevant.

Details of contact made

Name of doctor

Signature of doctor

Date



## Basic Fatigue Management - FITNESS TO DRIVE REPORT

(Note: this report relates to the driver's fitness for duty and is not to be used for driver licensing assessments)

<b>Driver information:</b>	Surname:	Given name(s):	
Address:			
Phone:	Date of birth:	Driver licence no.	State of issue:
<b>Employer information:</b>	Name:		
Address:		Contact phone number:	
<b>Nature of driving duties:</b>			

<b>Assessment outcome:</b>	
I was familiar with the driver's medical history before conducting this assessment	<input type="checkbox"/> Yes <input type="checkbox"/> No
I have sighted the driver's licence	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>I have examined the driver in accordance with the Assessing Fitness to Drive 2016 standards for commercial vehicle drivers. In my opinion the driver (tick ONE box from 1 to 4 and indicate recommended management and timing of next review):</p> <p><input type="checkbox"/> <b>1. Unconditionally meets the medical criteria for fitness to drive</b> Meets all relevant medical criteria. No restrictions or conditions. See <b>timing of next review</b> below.</p> <p><input type="checkbox"/> <b>2. Conditionally meets the medical criteria for fitness to drive</b> Has a medical condition that may impact on fitness to drive, but it is well controlled and meets the <b>conditional</b> criteria in Assessing Fitness to Drive 2016. May require person to be reviewed more frequently than standard. See <b>recommended management and timing of next review</b> below. Person is required to wear the following aids/devices: <input type="checkbox"/> Corrective lenses    <input type="checkbox"/> Hearing aid    <input type="checkbox"/> Other aids/devices (specify):</p> <p><input type="checkbox"/> <b>3. Temporarily does not meet the medical criteria for fitness to drive</b> Does not meet relevant medical criteria (unconditional or conditional) and should not undertake normal driving duties. May perform alternative tasks. May return to driving following: an improvement in condition, response to treatment or confirmed diagnosis of undifferentiated illness. See <b>recommended management and timing of next review</b> below.</p> <p><input type="checkbox"/> <b>4. Permanently does not meet the medical criteria for fitness to drive</b> Does not meet relevant medical criteria and cannot perform normal driving duties in the foreseeable future.</p> <p><b>Recommended management:</b></p> <p><input type="checkbox"/> Local doctor referral                      <input type="checkbox"/> Shorter review interval than standard (see <b>timing of next review</b> below)  <input type="checkbox"/> Specialist referral                              <input type="checkbox"/> Other, please describe (attach information to the form if required)  <input type="checkbox"/> Laboratory tests  <input type="checkbox"/> Drug test</p>	

<b>Timing of next review (from date of assessment):</b>	
<input type="checkbox"/> 1 year (NHVAS & TruckSafe standard for 50 years and over)	<input type="checkbox"/> 3 years (NHVAS & TruckSafe standard for 49 years and under)
<input type="checkbox"/> Shorter review interval than standard (specify):	years / months / weeks (circle or highlight)

Health professional's details		
Name:	Phone:	Facsimile:
Practice address:		
Signature:	Date of assessment:	