

This form must be completed based on an examination by a nurse practitioner or physician. The cost for the completion of this form by your health care provider is the patient's responsibility and not a benefit of the Ontario Health Insurance Plan (OHIP) or the Ministry of Transportation.

Please submit this form using **one** of the following methods:

- **Medical Review Online:** DriverPortal <https://www.medicalreviewonline.mto.gov.on.ca>
- **Online Fax:** 416-235-3400/1-800-304-7889
- **Email:** drivermedicalreview@ontario.ca
- **Mail:** Ministry of Transportation Driver Medical Review Office
77 Wellesley St. W, Box 589
Toronto, M7A 1N3

Part 1. Driver Information

☐ Commercial Renewal

☐ Change of Class

If blank, patient may complete this section.

Drivers Licence Number	Class of Licence	Date of Birth (yyyy/mm/dd)
Last Name	First Name	Middle Name/Initials

Driver's Certification and Release of Information

I certify that the foregoing information is to the best of my knowledge correct and agree to this report and any future report from this examination only being given to the Ministry of Transportation.

Email Address	Telephone Number	Signature
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Part 2. Patient Health Information

To be completed by a nurse practitioner or physician. The examination must consider previous health history, where available, and current status that may affect the individual's ability to drive.

1. Vision

This section must be completed.

Eye	Without Correction	With Correction	Horizontal Visual Field	
Right	20/ _____	20/ _____	☐ Full	☐ Restricted
Left	20/ _____	20/ _____	☐ Full	☐ Restricted
Combined	20/ _____	20/ _____	☐ Full	☐ Restricted

History of ocular issues (disease or injury)? ☐ Yes ☐ No If yes, please describe _____

New finding from this examination? ☐ Yes ☐ No If yes, please describe _____

Does this patient meet commercial acuity standards of: Not poorer than 20/30 with both eyes open and examined together and not poorer than 20/100 in the weaker eye? ☐ Yes ☐ No

In the following sections, check "No" if there are no health issues to report. If 'Yes', please complete that section.

2. Cardiovascular Diseases

☐ Yes ☐ No

Tick all that apply. **With patient's consent**, where relevant and, if available, please attach cardiologist's consultation report.

☐ Coronary Artery Disease ☐ Heart Valve Disease ☐ Arrhythmia or Conduction Disturbance ☐ Other Cardiac Conditions

Diagnosis

Drivers Licence Number	Last Name	First Name	Middle Name/Initials
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Current Status: ☐ Under Investigation/Results pending ☐ Treated/resolved ☐ Unstable	NYHA Category if known ☐ 1 ☐ 2 ☐ 3 ☐ 4	Left Ventricular Ejection Fraction (if known) ☐ <35% ☐ ≤40% ☐ >40% ☐ ≥50%
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3. Respiratory Condition	☐ Yes ☐ No
Respiratory Impairment: ☐ Mild ☐ Moderate ☐ Severe	
Supplemental Oxygen: ☐ Occasional ☐ Continuous	

4. Diseases of the Musculo-Skeletal System (loss of limb, diseases of the joints).	☐ Yes ☐ No
Is there a loss of functional ability? ☐ Yes ☐ No If yes, please describe _____	
Could pain or medication affect ability to drive? ☐ Yes ☐ No If yes, please describe _____	

5. Diabetes or Hypoglycemia	☐ Yes ☐ No
Diabetes ☐ Type 1 ☐ Type 2 Treated/controlled by: ☐ Diet ☐ Non-Insulin ☐ Insulin	Hypoglycemia To the best of your knowledge, has the patient had an episode of severe hypoglycemia requiring outside intervention in the past 6 months? ☐ Yes ☐ No ☐ Unknown

6. Psychiatric Disorders	☐ Yes ☐ No	
Diagnosis ☐ Major Depressive Disorder ☐ Bipolar Disorder ☐ Schizophrenia ☐ Other Psychotic disorder/episode ☐ Other _____	Current Status ☐ Stable with symptoms resolved ☐ Stable with ongoing symptoms ☐ Improving with ongoing symptoms ☐ Deteriorating	Condition has remained stable ☐ Less than 3 months ☐ 3-6 months ☐ 6-12 months ☐ Greater than 12 months

7. Substance Use Disorders	☐ Yes ☐ No
Hazardous intake defined as a level of consumption or pattern of use which, if persistent, is likely to result in harm.	
Is there evidence of hazardous alcohol or drug intake?	☐ Yes ☐ No
To the best of your knowledge, is there evidence or reports of an alcohol or drug related seizure?	☐ Yes ☐ No
Is further investigation and/or treatment indicated or recommended?	☐ Yes ☐ No
Treatment	
Has the patient been referred to, or is currently enrolled in a treatment program?	☐ Yes ☐ No
Is the patient compliant with treatment recommendations?	☐ Yes ☐ No
Does the patient exhibit difficulty with cognition, attention, or judgement?	☐ Yes ☐ No

8. Seizures or Loss of Consciousness (excluding febrile or toxic seizures)	☐ Yes ☐ No
☐ Syncope - unexplained, vasovagal or with reversible cause ☐ Single Unexplained Seizure ☐ Epilepsy	
☐ Alcohol Withdrawal Seizure	
Work-up in progress ☐ Yes ☐ No Date of Last Seizure (yyyy/mm/dd) _____	

Drivers Licence Number	Last Name	First Name	Middle Name/Initials
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9. Neurological Disorders

☐ Yes☐ No

☐ Parkinson's Disease☐ Multiple Sclerosis☐ Traumatic Brain Injury☐ CVA

☐ Other (please specify) _____

Current status and limitations, if any:

10. Sleep Disorders

☐ Yes☐ No

☐ Sleep Apnea☐ Narcolepsy

Is patient compliant with treatment?

☐ Yes☐ No

Is treatment successful?

☐ Yes☐ No

Daytime episodes of cataplexy in the past 12 months?

☐ Yes☐ No☐ N/A

11. Cognitive Impairment

☐ Yes☐ No

Cognitive impairment that affects attention, judgement and problem solving, planning and sequencing, memory, insight, reaction time or visuospatial perception. If yes, please provide score of at least one cognitive screening (Mini-Mental Status Exam or Montreal Cognitive Assessment).

MMSE ____/30	MoCA ____/30
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☐ Dementia☐ Brain Injury or Tumour☐ Other (please specify) _____

12. Hearing

☐ Yes☐ No

Ability to perceive in the better ear, with or without a hearing aid, a forced whisper at a distance of 1.5 metres

☐ Yes☐ No

If a hearing deficit is identified, is the standard noted above met with hearing aid?

☐ Yes☐ No

13. Additional Comments or Detail

Additional Comments

Part 3. Practitioner's Information

I am this patient's:

☐ Nurse PractitionerRegistration Number _____☐ Continuing Care

☐ PhysicianCPSO _____☐ Episodic Care

Last Name

First Name

Mailing Address

Unit Number	Street Number	Street Name
City/Town		Province
		Postal Code
Telephone Number	Signature	Date of Exam (yyyy/mm/dd)

Personal information on this form is collected under the authority of Ontario Regulation 340/94, Drivers' Licences, made under the *Highway Traffic Act*, and is used for the purpose of evaluating fitness to operate a motor vehicle.

If you have any questions about the personal information collected on this form, please contact a Medical Review representative, Ministry of Transportation, Driver Medical Review Office by telephone at 416-235-1773 or 1-800-268-1481 or by mail at 77 Wellesley St W, Box 589, Toronto ON M7A 1N1 or email us at DriverMedicalReview@ontario.ca, or visit us at www.ontario.ca/driverimprovement.