DL-131 (4-12)

COGNITIVE IMPAIRMENT FORM

PLEASE TYPE OR PRINT ALL INFORMATION IN BLUE OR BLACK INK

pennsylvania
DEPARTMENT OF TRANSPORTATION

Driver Qualification Section
P.O. Box 68682
Harrisburg, PA 17106-8682
(717) 787-9662

THIS FORM APPROVED BY THE MEDICAL ADVISORY BOARD 4/13/12
Provider: For more information relating to Medical Reporting, visit http://www.dmv.state.pa.us/centers/medicalReportingCenter.shtml.

PATIENT INFORMATION (PLEASE COMPLETE THIS FORM IN ITS ENTIRETY)

DRIVER'S LICENSE NO.	LAST NAME(S)	JR. ETC	FIRST NAME

HEIGHT		SEX	EYE COLOR	DATE OF BIRTH			TELEPHONE NUMBER	E-MAIL ADDRESS (If applicable)
FEET	INCHES			MONTH	DAY	YEAR		

STREET ADDRESS: P.O. Box number may be used in addition to the actual address, but cannot be used as the only address.		
CITY	STATE	ZIP CODE

1. How long have you been treating the patient? _____

2. Has this patient been diagnosed with cognitive impairment? _____

3. Has this patient been diagnosed with dementia or alzheimer's disease? _____

   If yes, indicate the stage of the patient's impairment. _____

4. Does the patient have impairment of any of the following areas which would make him/her unsafe to drive? Please answer "Yes" or "No" and explain "Yes" answers.
   a. Attentiveness to the task of driving? _____
   b. Judgment and problem solving? _____
   c. Reaction time? _____
   d. Planning and sequencing? _____
   e. Use of reasonable caution? _____
   f. Visuospatial perception? _____
   g. Memory? _____

5. Does the patient have excessive aggressiveness or disregard for the safety of self and/or others that would make him/her unsafe to drive? _____

6. Is the patient being treated with medication? . . . . . ❑ YES ❑ NO
   a. If yes, does the medication make him/her unsafe to drive a motor vehicle? . . . . . ❑ YES ❑ NO
   b. If no, how is this condition(s) being addressed? _____

HEALTH CARE PROVIDER INFORMATION (Please print or type)

HEALTH CARE PROVIDER'S NAME	SPECIALTY	HEALTH CARE PROVIDER'S LICENSE NUMBER	
STREET ADDRESS	CITY	STATE	ZIP CODE
TELEPHONE NUMBER	FAX NUMBER		

I hereby state that the facts above set forth are true and correct to the best of my knowledge, information and belief. I understand that the statements made herein are made subject to the penalties of 18 Pa. C. S. §4904 (relating to unsworn falsification to authorities) punishable by a fine up to $2,500 and/or imprisonment up to 1 year.

_____ Health Care Providers Signature

_____ Date