DL-104 (4-12)

GENERAL PSYCHIATRIC FORM

PLEASE TYPE OR PRINT IN BLUE OR BLACK INK ALL INFORMATION

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 the patient been diagnosed with a mental or emotional disorder? _____
3. With what disorder(s) has the patient been diagnosed? _____
4. Does the patient have significant impairment relating to attentiveness to the task of driving due to any symptom of a disorder, including but not limited to preoccupation, hallucination or delusion? _____
5. Does the patient contemplate suicide to the extent he/she would be unsafe to drive? _____
6. Does the patient have excessive aggressiveness or disregard for the safety of self or others or both, presenting a clear and present danger? _____
7. Does the patient have impairment of any of the following areas which would make him/her unsafe to drive?
   a. Attention (confusion, clouding or lapses of consciousness, distractibility, reduced response time, preoccupation, repetitive states of inattention, etc.)? _____
   b. Intellectual functioning (memory defects, capacity to organize a sudden complex series of stimuli, etc.)? _____
   c. Perception (visual and auditory, etc.)? _____
   d. Reaction time? _____
   e. Coordination of movement of the extremities? _____
   f. Muscular strength? _____
   g. Personality factors such as, but not limited to irresponsibility, emotional instability under stress? _____
8. Is the patient being treated with medication? _____ If yes, type and dosage: _____
   Does the medication make him/her an unsafe driver? _____

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 fact 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. 4909 (relating to unsworn falsification to authorities) punishable by a fine up to $2,500 and/or imprisonment up to 1 year.

_____ _____

Health Care Provider's Signature | Date