DL-121 (12-12)

SEIZURE REPORTING FORM

PLEASE TYPE OR PRINT IN BLUE OR BLACK INK ALL INFORMATION

pennsylvania
DEPARTMENT OF TRANSPORTATION

Bureau of Driver Licensing, P.O. Box 68682, Harrisburg, PA 17106-8682, (717) 787-9662

THIS FORM APPROVED BY THE MEDICAL ADVISORY BOARD 11/16/2012
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 (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. Did the patient have a seizure?_____

   If yes, date of the seizure: _____

3. Has the patient had more than one seizure? _____

4. Does the patient have an electrically diagnosed seizure disorder? _____

5. Has the patient had an EEG?_____ If yes, date of EEG: _____

6. Is the patient being treated with medication? _____ If yes, type and dosage:_____

   Does the medication affect the patient's ability to safely operate a motor vehicle? _____

7. Other than a seizure disorder, does the patient have episode(s) of loss of consciousness or awareness

   that would interfere with the safe operation of a motor vehicle? _____

   If yes, please explain: _____

8. Does the patient have seizure(s) attributable to a **prescribed** change in or removal from medication? _____

   If yes, when was the medication changed/discontinued? _____

   If yes, date of last seizure: _____

   Has the original medication been reintroduced?_____

PATIENT NAME_____ DRIVER'S LICENSE NUMBER_____

9. Does the patient have seizure(s) always preceded by a specific prolonged aura? _____

   If yes, what is the duration of the aura? _____

   How is it manifested? _____

   Has the patient experienced the aura for at least 2 years? _____

10. Does the patient experience only an aura? _____

    How is it manifested? _____

    Has the patient experienced only an aura for at least 2 years? _____

11. Does the patient have a pattern of seizure(s) occurring only during sleep or immediately

    upon awakening?_____ Has the patient experienced this pattern for at least 2 years? _____

12. Were the only seizure(s) the patient had within the last 6 months attributable to a nonrecurring transient

    illness, toxic ingestion, or metabolic imbalance? _____

    If yes, please explain and include dates of seizure(s): _____

    _____

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 Provider's Signature Date