

# CONFIDENTIAL MORBIDITY REPORT- DMV

**PLEASE NOTE: Use this form for reporting lapses of consciousness or control, Alzheimer's disease or other conditions which may impair the ability to operate a motor vehicle safely (pursuant to H&S 103900).**

## CONDITION BEING REPORTED

<b>Patient Name - Last Name</b>		<b>First Name</b>		<b>MI</b>	<b>Ethnicity (check one)</b>	
<b>Home Address: Number, Street</b>				<b>Apt./Unit No.</b>		
<b>City</b>		<b>State</b>	<b>ZIP Code</b>			
<b>Home Telephone Number</b>		<b>Cell Telephone Number</b>		<b>Work Telephone Number</b>		
<b>Email Address</b>			<b>Primary Language</b>			
<b>Birth Date (mm/dd/yyyy)</b>		<b>Age</b>	<b>Gender</b>			
		<input type="checkbox"/> Years <input type="checkbox"/> Months <input type="checkbox"/> Days	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____			
<b>Pregnant?</b>		<b>Est. Delivery Date (mm/dd/yyyy)</b>		<b>Country of Birth</b>		
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				<input type="checkbox"/> M to F Transgender <input type="checkbox"/> Male <input type="checkbox"/> F to M Transgender <input type="checkbox"/> Female <input type="checkbox"/> Other: _____		
<b>Occupation or Job Title</b>			<b>Occupational or Exposure Setting (check all that apply):</b>			
			<input type="checkbox"/> Food Service <input type="checkbox"/> Day Care <input type="checkbox"/> Health Care <input type="checkbox"/> Correctional Facility <input type="checkbox"/> School <input type="checkbox"/> Other (specify): _____			
<b>Date of Onset (mm/dd/yyyy)</b>		<b>Date of First Specimen Collection (mm/dd/yyyy)</b>			<b>Date of Diagnosis (mm/dd/yyyy)</b>	
<b>Reporting Health Care Provider</b>		<b>Reporting Health Care Facility</b>				<b>REPORT TO:</b>  <b>Orange County Public Health</b>  <b>Fax:</b> (714) 564-4050  <b>Mail:</b> P.O. Box 6128 Santa Ana, CA 92706-0128  <b>Phone:</b> (714) 834-8180
<b>Address: Number, Street</b>			<b>Suite/Unit No.</b>			
<b>City</b>		<b>State</b>	<b>ZIP Code</b>			
<b>Telephone Number</b>		<b>Fax Number</b>				
<b>Submitted by</b>		<b>Date Submitted (mm/dd/yyyy)</b>				

### DEPARTMENT OF MOTOR VEHICLES (DMV)

**California Driver License or Identification Card Number** (eight characters):

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1. If this report is based upon episodic lapses of consciousness, when was the most recent episode?: \_\_\_\_\_  
(mm/dd/yyyy)
2. If there have been multiple episodes of loss of consciousness or control within the past three years, please indicate the dates if they are known to you.  
(a): \_\_\_\_\_ (b): \_\_\_\_\_ (c): \_\_\_\_\_ (d): \_\_\_\_\_ (e): \_\_\_\_\_ (f): \_\_\_\_\_  
(mm/dd/yyyy) (mm/dd/yyyy) (mm/dd/yyyy) (mm/dd/yyyy) (mm/dd/yyyy) (mm/dd/yyyy)
3. Within the past 12 months, has there been an episode of loss of consciousness or control while driving?  Yes  No  Uncertain
4. Are additional lapses of consciousness likely to occur?  Yes  No  Uncertain
5. If the patient has had episodes of nocturnal seizures, is there likelihood of lapses of consciousness occurring while he/she is awake?  Yes  No  Uncertain
6. Has this patient been diagnosed with dementia or Alzheimer's disease?  Yes  No  Uncertain
7. Would you currently advise this patient not to drive because of his/her medical condition?  Yes  No  Uncertain
8. Does this patient's condition represent a permanent driving disability?  Yes  No  Uncertain
9. Would you recommend a driving evaluation by DMV?  Yes  No  Uncertain

**Remarks:**