

CONFIDENTIAL MORBIDITY REPORT

PLEASE NOTE: Use this form for reporting lapses of consciousness, 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

Patient Name - Last Name		First Name		MI	Ethnicity (check one)	
Home Address: Number, Street				Apt./Unit No.		<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Unknown
City		State	ZIP Code		Race (check all that apply)	
Home Telephone Number		Cell Telephone Number		Work Telephone Number		<input type="checkbox"/> African-American/Black
Email Address			Primary Language		<input type="checkbox"/> American Indian/Alaska Native	
Birth Date (mm/dd/yyyy)		Age	Gender		<input type="checkbox"/> Asian (check all that apply)	
		<input type="checkbox"/> Years <input type="checkbox"/> Months <input type="checkbox"/> Days	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____		<input type="checkbox"/> Asian Indian <input type="checkbox"/> Hmong <input type="checkbox"/> Thai	
Pregnant?		Est. Delivery Date (mm/dd/yyyy)		Country of Birth		<input type="checkbox"/> Cambodian <input type="checkbox"/> Japanese <input type="checkbox"/> Vietnamese
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown						<input type="checkbox"/> Chinese <input type="checkbox"/> Korean <input type="checkbox"/> Other (specify): _____
						<input type="checkbox"/> Filipino <input type="checkbox"/> Laotian
						<input type="checkbox"/> Pacific Islander (check all that apply)
						<input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Samoan
						<input type="checkbox"/> Guamanian <input type="checkbox"/> Other (specify): _____
						<input type="checkbox"/> White
						<input type="checkbox"/> Other (specify): _____
						<input type="checkbox"/> Unknown
Occupation or Job Title			Occupational or Exposure Setting (check all that apply):			
			<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): _____			
Date of Onset (mm/dd/yyyy)		Date of First Specimen Collection (mm/dd/yyyy)		Date of Diagnosis (mm/dd/yyyy)		
Reporting Health Care Provider		Reporting Health Care Facility		REPORT TO:		
Address: Number, Street		Suite/Unit No.				
City		State	ZIP Code			
Telephone Number		Fax Number				
Submitted by		Date Submitted (mm/dd/yyyy)				
				(Obtain additional forms from your local health department.)		

DEPARTMENT OF MOTOR VEHICLES (DMV)

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

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: