MENTAL HEALTH EVALUATION

DEPARTMENT OF PUBLIC SAFETY
Medical Advisory Committee
PO Box 11415•3600 N. M.L. King Avenue
Oklahoma City, OK 73136-0415

Print Name:_____

Driver Lic. No.:_____

Date of Birth:_____

INSTRUCTIONS: To assist us in determining whether to grant driving privileges to this applicant or licensee who has received psychotherapy and/or hospital care from you for emotional problems, please complete the following questionnaire. Upon completion, this form is to be returned directly by you to the Department of Public Safety. ANY PROFESSIONAL FEE IS THE RESPONSIBILITY OF THE APPLICANT. **THIS REPORT IS TO BE COMPLETED BY A LICENSED PSYCHIATRIST, OKLAHOMA LICENSED PSYCHOLOGIST, DOCTORAL LEVEL PSYCHOLOGIST LICENSED FOR INDEPENDENT PRACTICE IN ANOTHER STATE, OR A LICENSED PHYSICIAN QUALIFIED IN MENTAL HEALTH ISSUES.**

1. Is this individual prone to act on sudden impulse without regard for the consequences of his or her behavior?
   Yes No
   Comments: _____

2. Do you consider this individual to have sufficient regard for his or her personal safety to operate a motor vehicle safely? Yes No
   Comments: _____

3. Does this individual have sufficient regard for the safety of others to operate a motor vehicle safely?
   Yes No
   Comments: _____

4. Comments regarding this individual's emotional adjustment which would *favor* issuing or retaining a driver license:

5. Comments regarding this individual's emotional adjustment which would *contraindicate* issue or retention of a driver license:

6. What is the patient's diagnosis?_____

DI M107
Rev 09/2002

7. How long have you been treating this patient? _____

8. Medications prescribed:

_____ _____

_____ _____

Is there evidence that these medications and/or dosage could affect the driving ability? Yes No

If yes, please explain: _____

_____

If medication has been discontinued, give date: _____

9. List any other significant medical conditions:

_____

10. In your professional judgement, is the condition of the patient STABLE: if Yes, is the patient capable of demonstrating rational decisions?

Yes Length of current stable period: _____

No Please explain: _____

_____

11. Other comments: _____

12. Has the patient been recently, (or within the last twelve months) required to have inpatient treatment?

_____

DATE OF THIS EXAM: _____

_____
SIGNATURE OF DOCTOR

DOCTOR:
Please mail forms direct to:

Department of Public Safety
Exec Secy. Medical Advisory Committee
P.O. Box 11415
Oklahoma City, OK 73136-0415

_____
PRINT NAME OF DOCTOR

_____
SPECIALTY

_____
LICENSE # AND STATE OF

_____
MAILING ADDRESS

_____
CITY, STATE AND ZIP

(_____)_____
TELEPHONE

MAB USE ONLY