Diabetes Treatment Information for DOT Medical Certificate

Patient Name: ______________________________ **Date:** _________________________

Patients date of birth: _________________________

Please indicate the name and address of the overseeing physician treating the aforementioned patient for diabetes:

____

____

When was your patient's diabetes diagnosed? ____

1. Please indicate the date and result of the patients last hemoglobin A1C test:

   ____

2. List the medications being used to treat the patients diabetes:

   ____

   ____

3. Does the patient exhibit any side effects of the above-mentioned medications that would interfere with his/her ability to drive a commercial motor vehicle ? *Please indicate in the space below **(YES/NO)**.* If yes, please explain:

   ____

   ____

4. Does the patient have any complications from diabetes? (*ie. Kidney disease, cardiovascular, neurologic, retinopathy*). *Please indicate in the space below **(YES/NO)**.* If yes, please explain:

   ____

5. When was your patient's last dilated eye exam?____

6. Has the patient had a severe hypoglycemic or hyperglycemic reaction in the last 12 months that caused a seizure, loss of consciousness, or has required assistance from another individual or hospitalization? *Please indicate in the space below **(YES/NO)**.* If yes, please explain (with date of occurrence):

   ____

   ____

7. Do you feel that your patient can safely drive a commercial motor vehicle ? *Please indicate in the space below **(YES/NO)**.* If No, please explain:

   ____

   ____

_______________________________ _______________________________

Physician Name **License #**

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