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*

Home Address: Number, Street | *Apt./Unit No.*

City | *State* | *ZIP Code*

Home Telephone Number | *Cell Telephone Number* | *Work Telephone Number*

Email Address | *Primary Language* ☐ English ☐ Spanish ☐ Other: ______

Birth Date (mm/dd/yyyy) | *Age* ☐ Years ☐ Months ☐ Days | *Gender* ☐ Male ☐ Female ☐ M to F Transgender ☐ F to M Transgender ☐ Other: ______

Pregnant? ☐ Yes ☐ No ☐ Unknown | *Est. Delivery Date (mm/dd/yyyy)* | *Country of Birth*

Ethnicity (check one)
☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Unknown

Race (check all that apply)
☐ African-American/Black
☐ American Indian/Alaska Native
☐ Asian *(check all that apply)*
- ☐ Asian Indian ☐ Hmong ☐ Thai
- ☐ Cambodian ☐ Japanese ☐ Vietnamese
- ☐ Chinese ☐ Korean ☐ Other *(specify)*: ______
- ☐ Filipino ☐ Laotian

☐ Pacific Islander *(check all that apply)*
- ☐ Native Hawaiian ☐ Samoan
- ☐ Guamanian ☐ Other *(specify)*: ______

☐ White
☐ Other *(specify)*: ______
☐ Unknown

Occupation or Job Title | *Occupational or Exposure Setting (check all that apply):* ☐ Food Service ☐ Day Care ☐ Health Care ☐ Correctional Facility ☐ School ☐ 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*

Address: Number, Street | *Suite/Unit No.*

City | *State* | *ZIP Code*

Telephone Number | *Fax Number*

Submitted by | *Date Submitted (mm/dd/yyyy)*

REPORT TO:

(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): ______ *(mm/dd/yyyy)* (b): ______ *(mm/dd/yyyy)* (c): ______ *(mm/dd/yyyy)* (d): ______ *(mm/dd/yyyy)* (e): ______ *(mm/dd/yyyy)* (f): ______ *(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: