STATE OF CONNECTICUT DEPARTMENT OF MOTOR VEHICLES 60 STATE STREET, WETHERSFIELD, CT 06161-1013 DRIVER SERVICES DIVISION telephone: (860)263-5723 email: dmv.suspension@ct.gov



Department of Aging and Disability Services (ADS) / Driver Training Program (DTP) Referral П

INSTRUCTIONS

 Patient: Complete section (A).
 Medical examiner(s) (licensed physician, PA or APRN): Complete section (B) and all subsections of section (C) based on the results of a personal examination conducted within ninety (90) days of the completion of this report. Attach other information as necessary, including any technical reports or test

results.			o lopoli			,	unig uniy to t	in noai ropo	
Submission of this report to may be brought against any medical reports may be refe patient's ability to safely op to hold an operator's license	person who, in good faith rred to the DMV's Medical erate a motor vehicle. Bas	, provides a report to t Advisory Board (MAB)	he DMV) for rev	7. Pursuant to Se iew. The MAB m	ctions 14-46b ay request ad	and 14-46c of the (ditional medical inf	Connecticut formation in	General Stat determining	tutes, the
Section (A): Patie	nt Information								
NAME (Last, First, Middle)				DATE OF BIRTH		OPERATOR'S LICEN	ISE NUMBER		
MAILING ADDRESS (Street)	(City)		(State)		(Zip Code)	PATIENT	S PHONE NUM	MBER
Commercial Driver's Lice or Applicant (CLP)?	ense (CDL) Holder	YES NO		senger Endors Applicant?	sement (PPE	E) Holder	YES		
I hereby understand that n may submit copies of my r SIGNATURE OF DRIVER / PATIE	medical records to the DN	/IV and ADS.	aminat	ion to determin	e my fitness	·	r vehicle sa	fely, and tha	at (s)he
X						55			
PATIENT AUTHORIA			if yoι	ı authorize ti	he DMV's	Driver Services	s Division	to discus	ss your
(Please Print)									D. 4050
I, DIVISION TO DISCUSS N	AY MEDICAL CASE WIT				DEPARTME	NT OF MOTOR V	EHICLES' [DRIVER SE	RVICES
			0) 10, 11						
				2		DATE			
SIGNATURE OF DRIVER / PATIE	NI					DATE			
If medical reporting is re condition-specific subse office visits for the patie the medical examiner n	ection of section (C). ent. If the patient has	This <u>only</u> pertains t "no known conditio	to med n" in a	lical reports to specific subs	be filed wit	th the DMV and	not to rout	inely sche	duled
Section (B): Clinic									
The person named above vehicle due to the medic			ate a m	otor					
If this box is checked, the a and the remainder of the f									
REGARDING: (DMV use only)									
<u>If applicable</u> , has the inc	ident dated	been discuss	ed fully	with the patie	ent? 🗌 YE	S 🗌 NO			
Indicate any present con	ditions that may affect	this patient's fitness	s to dri	ve safely:					
Do you believe this perse *If YES, please indic		o another physician	/speci	alist? 🗌 YE	S* [NO			
Do you believe this perse	on should be required t	to complete a DMV i	road te	st to determin	e driving ab	ility? 🗌 YES		NO	
MEDICAL REPORTING GENERAL	Considering this patient that there have been							YES*	NO
*If YES, for which condit	ion(s):	How often	n shou	ld a report be	filed? Eve	ry	months fo	r	year(s).
	-110 and 53a-157b of the Co le and correct. I also certify t								nd any
MEDICAL EXAMINER'S SIGNATU				s paneta traini	TELEPHONE			INATION DATI	E

DATE SIGNED

SPECIALTY

MEDICAL EXAMINER'S NAME (Please Print)

MEDICAL FORM P-142M Rev.04-22

LICENSE NUMBER:

Section (C)): Condition-Specific Infor	mation (Continued on F	Page 3)			
			OLOGY			
If the patient has box.	s no known cardiac condition, the b	ox below must be checked,	and the medica	<i>I examiner must provide initials a</i> Medical Exam		
The patient ha	as no known cardiac conditio	n. 🗌		Initials and Da		
If present, name	e(s) of specific cardiac condition	(s) :				
Has the patient	suffered lost or altered consciou	isness/awareness?	YES*			
	odes of lost or altered consciousness/av					
DATE	TYPE/CAU	SE	DATE	TYPE	E/CAUSE	
Considering this patient's condition, do you believe this person may safely operate a motor vehicle?						
If a cardiac condition is present, is the patient following the physician's prescribed protocol?						
*lf <i>NO</i> , d	loes it affect the patient's ability t	o safely operate a motor	vehicle?		NO	
MEDICAL REP CARDIOLC	oonsidering this parts	<i>i</i> i		be submitted to the DMV to ensely operate a motor vehicle?	ure YES* NO	
*If YES, How of	ften should a report be filed?	Every	month	is for	_ year(s).	
	Sections 14-110 and 53a-157b of the Co nereto, is true and correct. I also certify th					
MEDICAL EXAMINE	R'S SIGNATURE	LICENSE NUMBER		TELEPHONE NUMBER	EXAMINATION DATE	
X MEDICAL EXAMINE	R'S NAME (Please Print)	SPECIALTY		DATE SIGNED		
		DIABETES / META	BOLIC SYND	DROME		
If the patient has the checked box	s no known diabetic/metabolic cond ĸ.	ition, the box below must b	e checked, and			
The patient ha	as no known diabetic/metabo	lic condition. 🗌		Medical Exam Initials and Da		
If diabetes/meta	abolic condition is present, has t	he patient suffered lost o	r altered consci	ousness/awareness? 🗌 YE	S* 🗌 NO	
*If YES, state episo	odes of lost or altered consciousness/av	vareness within the past six me	onths <i>(begin with t</i>	he most recent date):		
DATE	TYPE/CAU	SE	DATE	TYPE	E/CAUSE	
Considering thi	ı is patient's condition, do you beli	eve this person may safe	ely operate a mo	otor vehicle?		
Is there signific	cant neuropathy? 🗌 YES*] NO		es it affect motor vehicle opera	ation? 🗌 YES 📃 NO	
Has the patient	suffered retinopathy to the point	of vision loss?	S* 🗌 NO	*If YES, form P-142OP	must be submitted.	
	tabolic condition is present, is th	e patient following the pl	nysician's prese	cribed protocol?	□ NO*	
(Inclusive of medic *If NO. d	cation(s)) loes it affect the patient's ability t	o safelv operate a motor	vehicle?	T YES		
	,					
MEDICAL REP DIABETES/MET	eeneldering the parts			be submitted to the DMV to ensely operate a motor vehicle?	ure YES* NO	
*If YES, How often should a report be filed? Every months for year(s).						
*If YES, How of	ften should a report be filed?	Every	month	is for	_ year(s).	
Pursuant to S	ften should a report be filed? Sections 14-110 and 53a-157b of the Co nereto, is true and correct. I also certify th	nnecticut General Statutes, I s	wear, under penalt	y of deliberate false statement, that th	e above information, and any	
Pursuant to S	Sections 14-110 and 53a-157b of the Co nereto, is true and correct. I also certify th	nnecticut General Statutes, I s	wear, under penalt	y of deliberate false statement, that th	e above information, and any	
Pursuant to S attachment h MEDICAL EXAMINE X	Sections 14-110 and 53a-157b of the Co nereto, is true and correct. I also certify th	nnecticut General Statutes, I s nat I have personally examined	wear, under penalt	y of deliberate false statement, that th the ninety (90) days preceding the co	e above information, and any mpletion of this report.	

MEDICAL FORM	
P-142M Rev.04-22	

LICENSE NUMBER:

Section (C): Condition-Specific Information (Continued on Page 4)							
NEUROLOGY							
If the patient has checked box.	s no known neurological condition, t	he box below must be cheo	cked, and the m	edical examiner must	provide initials	s and a date next to the	
The patient has no known neurological condition.							
If present, name	e(s) of specific neurological conc	lition(s) :					
State episodes of I	ost or altered consciousness/awareness	s within the past six months (<u>b</u>	egin with the most	<u>t recent date</u>):			
DATE	TYPE/CAU	SE	DATE		TYPE/C	AUSE	
Considering thi	Considering this patient's condition, do you believe this person may safely operate a motor vehicle?						
	If a neurological condition is present, is the patient following the physician's prescribed protocol?						
*lf <i>NO</i> , d	oes it affect the patient's ability t	o safely operate a motor	vehicle?	[YES] NO	
MEDICAL REP NEUROLC		ent's condition, should pe no changes in the patient'				e 🗌 YES* 🗌 NO	
*If YES, How of	ten should a report be filed?	Every	month	ns for	¥	vear(s).	
	Sections 14-110 and 53a-157b of the Co ereto, is true and correct. I also certify th						
MEDICAL EXAMINER	R'S SIGNATURE	LICENSE NUMBER		TELEPHONE NUMBER		EXAMINATION DATE	
X MEDICAL EXAMINE	R'S NAME (Please Print)	SPECIALTY		DATE SIGNED			
		ORTHO	OPEDIC				
If the patient has checked box.	no known orthopedic condition, the	e box below must be check	ed, and the med				
The patient ha	as no known orthopedic cond	lition.			ledical Examine hitials and Date	r	
ADS / DTP R	Referral	Due to this pa PRIOR to com	tient's medical pleting the DT	condition, (s)he is N P through ADS.	NOT fit to safe	ely operate a motor vehicle	
If present, name	e(s) of specific orthopedic condit	ion(s):					
Is this a progre	ssive illness?	ΝΟ					
*If <i>YES</i> , (does it affect the patient's ability	to safely operate a motor	vehicle?	YES 🗌 NO			
Is this patient's	movement limited? YES*						
*If <i>YES</i> , (does it affect the patient's ability	to safely operate a motor	vehicle?	YES 🗌 NO			
Are there splint *If YES,	s or appliances that should be w specify:	orn while patient is opera	iting a motor ve	ehicle?	YES*] NO	
SPECIAL EQUI LICENSE RESTRICTIO	Connecticut State Age	4-36a of the Connecticut encies, the patient may op					
MECHANICAL AID ("C" Restriction) PROSTHETIC AID ("D" Restriction) AUTOMATIC TRANSMISSION ("D" Restriction) ("D" Restriction)							
MEDICAL REPORTING ORTHOPEDIC Considering this patient's condition, should periodic reports be submitted to the DMV to ensure YES* NO that there have been no changes in the patient's fitness to safely operate a motor vehicle?							
*If YES, How of	ten should a report be filed?	Every	month	ns for	»	vear(s).	
Pursuant to S attachment h	Sections 14-110 and 53a-157b of the Co ereto, is true and correct. I also certify th	nnecticut General Statutes, I sv at I have personally examined	wear, under penalt this patient within	y of deliberate false state the ninety (90) days pred	ement, that the a ceding the comp	above information, and any letion of this report.	
	R'S SIGNATURE	LICENSE NUMBER		TELEPHONE NUMBER		EXAMINATION DATE	
X MEDICAL EXAMINE	R'S NAME (Please Print)	SPECIALTY		DATE SIGNED			

MEDICAL FORM P-142M Rev. 04-22										
Section (C): Condition-Specific Info	rmation									
	PSYCHIATRIC / SU	JBSTANCE	ABUSE							
If the patient has no known psychiatric/substance next to the checked box.	abuse condition, the box bel	ow must be che	cked, and the medical examiner	must provide initials and a date						
The patient has no known psychiatric / s	ubstance abuse conditio	on. 🗆 🔄	Medical Examiner Initials & Date							
If present, name(s) of specific psychiatric/subs	stance abuse condition(s):									
Considering this patient's condition, do you be	elieve this person may safe	ly operate a m	otor vehicle? YES	NO NO						
Do you have reason to suspect the patient abu	ses alcohol, medications,	or illicit drugs?								
**If YES, does this prevent the patient f	om operating a motor vehi	cle safely?	fely?							
Does this patient suffer from convulsive seizures?										
*If YES, state episodes within the past six months (begin	with the most recent date):									
DATE TYPE/CA	USE	DATE	TYP	E/CAUSE						
List any known medication(s) that may impact	the patient's ability to safe	ly operate a m	otor vehicle:							
MEDICAL REPORTING Considering t	his patient's condition, sho	ould periodic re	ports be submitted to the DM	′						
	there have been no chang		nt's fitness to safely operate a							
*If YES, How often should a report be filed?	Every	mont	ns for	_ year(s).						
Pursuant to Sections 14-110 and 53a-157b of the C										
attachment hereto, is true and correct. I also certify MEDICAL EXAMINER'S SIGNATURE	LICENSE NUMBER	this patient within	TELEPHONE NUMBER	EXAMINATION DATE						
X MEDICAL EXAMINER'S NAME (Please Print)	SPECIALTY		DATE SIGNED							
	RESPIRATORY / S		RDERS							
If the patient has no known respiratory/sleep diso				initials and a date next to the						
checked box.		, 		If the patient has no known respiratory/sleep disorder, the box below must be checked, and the medical examiner must provide initials and a date next to the checked box.						
The patient has no known respiratory / sl	The patient has no known respiratory / sleep disorder condition. Image: Condition in the patient has no known respiratory / sleep disorder condition. Medical Examiner initials and Date									
If present, name(s) of specific respiratory/sleep disorder condition(s):										
it present, name(s) of specific respiratory/slee	o disorder condition(s):		Ir							
If present, name(s) of specific respiratory/slee Considering this patient's condition, do you be		ly operate a m								
	elieve this person may safe		otor vehicle?	itials and Date						
Considering this patient's condition, do you be If a respiratory/sleep disorder is present, is the (Inclusive of medication(s))	elieve this person may safe	sician's prescri	otor vehicle?	itials and Date NO NO*						
Considering this patient's condition, do you be If a respiratory/sleep disorder is present, is the (Inclusive of medication(s)) *If NO, does it affect the patient's ability	elieve this person may safe e patient following the phys r to safely operate a motor	sician's prescri	otor vehicle?	itials and Date NO NO* NO						
Considering this patient's condition, do you be If a respiratory/sleep disorder is present, is the (Inclusive of medication(s))	elieve this person may safe e patient following the phys to safely operate a motor pusness/awareness?	sician's prescri vehicle?	otor vehicle?	itials and Date NO NO*						
Considering this patient's condition, do you be If a respiratory/sleep disorder is present, is the (Inclusive of medication(s)) *If NO, does it affect the patient's ability Has the patient suffered lost or altered conscio	elieve this person may safe e patient following the phys to safely operate a motor pusness/awareness? wareness within the past six mor	sician's prescri vehicle?	otor vehicle? YES bed protocol? YES YES YES YES YES	itials and Date NO NO* NO						
Considering this patient's condition, do you be If a respiratory/sleep disorder is present, is the (Inclusive of medication(s)) *If NO, does it affect the patient's ability Has the patient suffered lost or altered conscie *If YES, state episodes of lost or altered consciousness/a	elieve this person may safe e patient following the phys to safely operate a motor pusness/awareness? wareness within the past six mor	sician's prescri vehicle? ^{hths} (<u>begin with t</u>	otor vehicle? YES bed protocol? YES YES YES YES YES	itials and Date NO NO* NO NO NO NO NO N						
Considering this patient's condition, do you be If a respiratory/sleep disorder is present, is the (Inclusive of medication(s)) *If NO, does it affect the patient's ability Has the patient suffered lost or altered conscious *If YES, state episodes of lost or altered consciousness/a DATE TYPE/CA Is this patient able to exhale 1000CC of air, in a	elieve this person may safe e patient following the phys to safely operate a motor pusness/awareness? wareness within the past six mor USE	sician's prescri vehicle? hths <u>(begin with th</u> DATE	otor vehicle? YES bed protocol? YES YES YES Ne most recent date): TYP	itials and Date NO NO* NO NO NO NO NO N						
Considering this patient's condition, do you be If a respiratory/sleep disorder is present, is the (Inclusive of medication(s)) *If NO, does it affect the patient's ability Has the patient suffered lost or altered conscious *If YES, state episodes of lost or altered conscious DATE TYPE/CA Is this patient able to exhale 1000CC of air, in or motor vehicle that contains an ignition interlood MEDICAL REPORTING Considering this patient	elieve this person may safe e patient following the phys to safely operate a motor pusness/awareness? wareness within the past six mor USE one continuous breath, dur ck device? ient's condition, should pe	sician's prescri vehicle? hths (begin with th DATE ing the operati riodic reports l	otor vehicle? YES bed protocol? YES YES YES YES TYP on of a YES be submitted to the DMV to ense	itials and Date NO NO* NO NO NO E/CAUSE NO						
Considering this patient's condition, do you be If a respiratory/sleep disorder is present, is the (Inclusive of medication(s)) *If NO, does it affect the patient's ability Has the patient suffered lost or altered conscious *If YES, state episodes of lost or altered conscious DATE TYPE/CA Is this patient able to exhale 1000CC of air, in or motor vehicle that contains an ignition interlood MEDICAL REPORTING Considering this patient	elieve this person may safe e patient following the phys to safely operate a motor ousness/awareness? wareness within the past six mor USE one continuous breath, dur ck device? ient's condition, should pe no changes in the patient'	sician's prescri vehicle? DATE DATE ing the operati riodic reports I s fitness to sat	otor vehicle? YES bed protocol? YES YES YES YES YES TYP On of a YES	itials and Date NO NO* NO NO NO E/CAUSE NO						
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Considering this patient's condition, do you be If a respiratory/sleep disorder is present, is the (Inclusive of medication(s)) *If NO, does it affect the patient's ability Has the patient suffered lost or altered conscious *If YES, state episodes of lost or altered consciousness/a DATE TYPE/CA Is this patient able to exhale 1000CC of air, in or motor vehicle that contains an ignition interlood MEDICAL REPORTING RESPIRATORY/SLEEP Considering this patient that there have been *If YES, How often should a report be filed? Pursuant to Sections 14-110 and 53a-157b of the C attachment hereto, is true and correct. I also certify	elieve this person may safe e patient following the phys to safely operate a motor ousness/awareness? wareness within the past six mor USE one continuous breath, dur ck device? ient's condition, should pe no changes in the patient' Every	sician's prescri vehicle? hths (<u>begin with th</u> DATE ing the operati riodic reports I s fitness to saf montil wear, under penal	otor vehicle? YES bed protocol? YES YES YES YES YES On of a YES VES VES VES YES VES VES VES VES VES VES VES VES VES V	itials and Date NO NO* NO NO NO NO KURE VES* NO year(s).						