

GF130

Form 1

QUESTIONNAIRE/MEDICAL EXAMINATION
FOR A DANGEROUS GOODS DRIVER LICENCE
Workplace Standards Tasmania
Dangerous Goods (Road and Rail Transport) Act 2010
Dangerous Goods (Road and Rail Transport) Regulations 2010



Tasmanian
Government

MEDICAL PRACTITIONER TO RETAIN

GENERAL GUIDELINES / CHECKLIST

Completion of Forms 1 & 2 is required to obtain a Dangerous Goods Driver Licence.

The questions in this Questionnaire/Medical Examination form are from AustRoads "Fitness to Drive"

- Complete questionnaire section on the next page before attending Medical Examination
- Take Form 1 and 2 to your Medical Practitioner who will complete Medical Examination Sections
- Medical Practitioner to retain Form 1
- Form 1 not to be completed anymore than 6 months prior to application
- Form 2 to be completed and given to Service Tasmania

Applicants Details:

Family Name

Given Names:

D.O.B

Residential Address:

Post Code

Telephone: (BH)

Telephone (AH)

Mobile

Personal information we collect from you will be used by the Delegate of the Competent Authority for dangerous goods licensing purposes and may be used for other purposes permitted by the *Dangerous Goods Act 2010* and associated laws. Failure to provide this information may result in your application being denied or records not being properly maintained. Your personal information may be disclosed to contractors and agents of Workplace Standards, law enforcement agencies, courts and other public sector bodies or organisations authorised to collect it. This information will be managed in accordance with the *Personal Information Protection Act 2004* and may be accessed by you on request to this Department. You may be charged a fee for this service.

Applicant to Complete

Please answer the questions by ticking the correct box. If you are not sure, leave blank and ask your doctor what it means. The doctor will ask you additional questions during the examination.

Question	YES	NO																		
1. Are you currently being treated by a doctor for illness or injury?																				
2. Are you receiving any medical treatment or taking any medication (either prescribed or otherwise) (please take any medications with you to show doctor)																				
3. Have you ever had, or been told by a doctor that you had any of the following?																				
3.1 High blood pressure																				
3.2 Heart disease																				
3.3 Chest pain, angina																				
3.4 Any condition requiring heart surgery																				
3.5 Palpitations/irregular heart beat																				
3.6 Abnormal shortness of breath																				
3.7 Head injury, spinal injury																				
3.8 Seizures, fits, convulsions, epilepsy																				
3.9 Blackouts, fainting																				
3.10 Stroke																				
3.11 Dizziness, vertigo, problems with balance																				
3.12 Double vision, difficulty seeing																				
3.13 Colour blindness																				
3.14 Kidney disease																				
3.15 Diabetes																				
3.16 Neck, back or limb disorders																				
3.17 Hearing loss or deafness or had an ear operation or use a hearing aid?																				
3.18 Do you have difficulty hearing people on the telephone (including use of hearing aid if worn)																				
3.19 Have you ever had, or been told by a doctor that you had a psychiatric illness, or nervous disorder?																				
3.20 Have you ever had any other serious injury, illness, operation, or been in hospital for any reason.																				
4.1 Have you ever had, or been told by a doctor that you had a sleep disorder, sleep apnoea or narcolepsy?																				
4.2 Has anyone noticed that your breathing stops or is disrupted by episodes of choking during your sleep																				
<p>4.3 How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way in recent times. Even if you haven't done some of these things recently try to work out how they would have affected you.</p> <p>Use the following scale to choose the most appropriate number for each situation:</p> <p>0 = Would never doze off 1 = Slight chance of dozing off 2 = Moderate chance of dozing off 3 = High chance of dozing off</p> <p>It is important that you put a number (0-3) in each of the 8 boxes.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">Situation</th> <th style="text-align: center;">Chance of Dozing (0-3)</th> </tr> </thead> <tbody> <tr> <td>Sitting and reading</td> <td></td> </tr> <tr> <td>Watching TV</td> <td></td> </tr> <tr> <td>Sitting, inactive in a public place (e.g. Movies)</td> <td></td> </tr> <tr> <td>As a passenger in a car for an hour without a break</td> <td></td> </tr> <tr> <td>Lying down to rest in the afternoon where circumstances permit</td> <td></td> </tr> <tr> <td>Sitting and talking to someone</td> <td></td> </tr> <tr> <td>Sitting quietly after lunch without alcohol</td> <td></td> </tr> <tr> <td>In a car, while stopped for a few minutes in the traffic</td> <td></td> </tr> </tbody> </table>			Situation	Chance of Dozing (0-3)	Sitting and reading		Watching TV		Sitting, inactive in a public place (e.g. Movies)		As a passenger in a car for an hour without a break		Lying down to rest in the afternoon where circumstances permit		Sitting and talking to someone		Sitting quietly after lunch without alcohol		In a car, while stopped for a few minutes in the traffic	
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Continued:

5. Please tick the answer that is correct for you:

5.1 How often do you have a drink containing alcohol?

Never Monthly 2 or 4 times a month 2 or 3 times a week 4 or more times a week

5.2 How many drinks containing alcohol do you have on a typical day when you are drinking?

1 to 2 3 to 4 5 to 6 7 to 9 10 or more

5.3 How often do you have six or more drinks on one occasion?

Never Less than monthly Monthly Weekly Daily or almost daily

5.4 How often during the last year have you found that you were not able to stop drinking once you have started?

Never Less than monthly Monthly Weekly Daily or almost daily

5.5 How often during the last year have you failed to do what was normally expected of you because of drinking?

Never Less than monthly Monthly Weekly Daily or almost daily

5.6 How often during the last year have you needed a drink in the morning to get yourself going after a heavy drinking session?

Never Less than monthly Monthly Weekly Daily or almost daily

5.7 How often during the last year have you had a feeling of guilt or remorse after drinking?

Never Less than monthly Monthly Weekly Daily or almost daily

5.8 How often during the last year have you been unable to remember what happened the night before because you had been drinking?

Never Less than monthly Monthly Weekly Daily or almost daily

5.9 Has someone else been injured as a result of your drinking?

No Yes, but not in the last year Yes, during the last year

5.10 Has a relative, friend, doctor or other health worker been concerned about your drinking or suggested you cut down?

No Yes, but not in the last year Yes, during the last year

6. Do you use illicit drugs?

No Yes

7. Do you use any drugs or medication not prescribed by your doctor?

No Yes

8. Have you been in a vehicle crash since your last examinations?

No Yes

If you answered Yes to Questions 6,7 or 8 please give details:

I,.....

Certify that to the best of my knowledge the above information supplied by me is true and correct.

Signature:..... Date:...../...../.....

IMPORTANT: For privacy reasons, the completed Applicant Questionnaire must not be returned to Workplace Standards Tasmania. Medical information relevant to driver licensing should be included on the Medical Certificate and on the Medical Condition Notification Form (for assessments made in the course of applicant's treatment).

Medical Practitioner to Complete

Appropriate tests other than those outlined here can be applied, e.g. Mini Mental State or equivalent for cognitive conditions. For privacy reasons this form must not be returned to Workplace Standards Tasmania. Please retain the applicant's medical history. Medical information and findings relevant to the person's fitness to drive should be recorded on the medical fitness to drive assessment on form 2.

1. Cardiovascular System:

1.1 Blood pressure (Repeat if necessary)

Systolic mm Hg mm Hg

Diastolic mm Hg mm Hg

1.2 Pulse Rate:..... Regular Irregular

1.3 Heart Sounds Normal Abnormal

1.4 Peripheral Pulses Normal Abnormal

2 Chest/Lungs Normal Abnormal

3. Abdomen (Liver) Normal Abnormal

4. Neurological/Locomotor:

4.1 Cervical Spine Rotation Normal Abnormal

4.2 Back Movement Normal Abnormal

4.3 Upper Limbs

(a) Appearance Normal Abnormal

(b) Joint Movements Normal Abnormal

4.4 Lower Limbs

(a) Appearance Normal Abnormal

(b) Joint Movements Normal Abnormal

4.5 Reflexes Normal Abnormal

4.6 Romberg's sign* Normal Abnormal

(*A pass requires the ability to maintain balance while standing with shoes off, feet together side by side, eyes closed and arms side by side for thirty seconds)

5. Vision

5.1 Visual Acuity

Uncorrected		Corrected	
R	L	R	L
6/	6/	6/	6/

Are contact lenses worn? Yes No

5.2 Visual Field (Confrontation to each eye)

Normal Abnormal

6. Urinalysis

6.1 Protein: Normal Abnormal

6.2 Glucose: Normal Abnormal

7. Neuropsychological Assessment

Where clinically indicated apply the Mini Mental State Questionnaire or General Health Questionnaire or equivalent.

Score:

RELEVANT MEDICAL FINDINGS

Note comments on any relevant findings detected in the questionnaire or examination, making reference to the requirements of the standards outlined in the AFTD Publication.

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