DL-124 (8-16)

pennsylvania
DEPARTMENT OF TRANSPORTATION

GENERAL NEUROLOGICAL FORM

PLEASE TYPE OR PRINT IN BLUE OR BLACK INK ALL INFORMATION

Bureau of Driver Licensing • P.O. Box 68682 • Harrisburg, PA 17106-8682 • (717) 787-9662

THIS FORM APPROVED BY THE MEDICAL ADVISORY BOARD 4/17/2015
Provider: For more information relating to Medical Reporting, visit www.dmv.pa.gov and click on the Medical Reporting tab under Information Centers.

PATIENT INFORMATION (Please complete this form in its entirety)

DRIVER'S LICENSE NUMBER	LAST NAME(S)	JR. ETC	FIRST NAME

HEIGHT FEET	HEIGHT INCHES	SEX	EYE COLOR	DATE OF BIRTH MONTH	DAY	YEAR	TELEPHONE NUMBER	E-MAIL (IF APPLICABLE)

STREET ADDRESS: P.O. Box number may be used in addition to the actual address, but cannot be used as the only address.	CITY	STATE	ZIP CODE

1. How long have you been treating the patient?_____
2. Has the patient been diagnosed with a cerebral vascular insufficiency? . . . . . ❑ YES ❑ NO
3. Has the patient had any of the following disqualifying episodes as a result of cerebral vascular insufficiency? . . . . . ❑ YES ❑ NO
   a. ❑ **Syncopal Attack** - Date of last episode _____ b. ❑ **Loss of Consciousness** - Date of last episode _____
   c. ❑ **Vertigo** - Date of last episode _____ d. ❑ **Paralysis** - Date of last episode _____
   e. ❑ **Loss of qualifying visual fields** - Date of last episode _____
4. Does the patient have impairment in any of the following areas?
   a. Reaction time? . . . . . ❑ YES ❑ NO
   b. Coordination of movement of the extremities? . . . . . ❑ YES ❑ NO
   c. Muscular strength? . . . . . ❑ YES ❑ NO
5. Does the patient have excessive aggressiveness or disregard for the safety of self or others? . . . . . ❑ YES ❑ NO
6. Does the patient have any cognitive impairment(s) including but not limited to attentiveness to the task of driving, judgement and problem solving, planning and sequencing, visuospatial perception and or memory? . . . . . ❑ YES ❑ NO
7. Do any yes answers above indicate that the customer should cease driving immediately? . . . . . ❑ YES ❑ NO
8. Is the patient being treated with medicine? . . . . . ❑ YES ❑ NO
9. Does the medication(s) make the patient unsafe to drive? . . . . . ❑ YES ❑ NO

   If yes, please specify _____

HEALTH CARE PROVIDER INFORMATION (Please print or type)

HEALTH CARE PROVIDER'S NAME	SPECIALTY	HEALTH CARE PROVIDER'S LICENSE NUMBER
	Neurology	

STREET ADDRESS	CITY	STATE	ZIP CODE
1151 Old York Road, Suite 200	**Abington**	**PA**	**19001**

TELEPHONE NUMBER	FAX NUMBER
(215) 957-9250	**(215) 957-9254**

I hereby state that the facts above set forth are true and correct to the best of my knowledge, information and belief. I understand that the statements made herein are made subject to the penalties of 18 Pa. C.S. § 4904 (relating to unsworn falsification to authorities) punishable by a fine up to $2,500 and/or imprisonment up to 1 year.

_____ _____

Health Care Provider's Signature Date