DL-128 (1-16)

pennsylvania
DEPARTMENT OF TRANSPORTATION

SUBSTANCE USE FORM

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

THIS FORM APPROVED BY THE MEDICAL ADVISORY BOARD 4/13/12

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 NO.	LAST NAME(S)	JR. ETC	FIRST NAME

HEIGHT		SEX	EYE COLOR	DATE OF BIRTH			TELEPHONE NUMBER	E-MAIL ADDRESS: (if applicable)
FEET	INCHES			MONTH	DAY	YEAR		

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. Does this patient use any drug or substance, including alcohol, known to impair driving skills or functions? _____

   If yes, please specify what substance(s): _____

3. In your opinion, does this patient abuse any drug or substance? _____

   If yes, what signs or symptoms of substance abuse does this patient currently have that would affect the safe operation of a motor vehicle? _____

   Discuss nature, extent, frequency, and control of pertinent symptoms: _____

   _____

4. Does this patient take any medication to control substance abuse? _____

   If so, please specify: _____

   Does this medication affect the patient's ability to drive? _____

5. Does this patient require treatment and/or counseling for substance abuse? _____

6. In your opinion, does the individual's substance use impair his/her ability to drive? . . . . ❑ Yes ❑ No

HEALTH CARE PROVIDER INFORMATION (Please print or type)

HEALTH CARE PROVIDER'S NAME	SPECIALTY	HEALTH CARE PROVIDER'S LICENSE #	
	Neurology		
STREET ADDRESS **1151 Old York Road, Suite 200**	CITY **Abington**	STATE **PA**	ZIP CODE **19001**
TELEPHONE NUMBER **(215) 957-9250**	FAX NUMBER **(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