DL-13 (4-12)

INITIAL REPORTING FORM

PLEASE TYPE OR PRINT IN BLUE OR BLACK INK ALL INFORMATION

pennsylvania
DEPARTMENT OF TRANSPORTATION

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 http://www.dmv.state.pa.us/centers/medicalReportingCenter.shtml.

SECTION A PATIENT INFORMATION

DRIVER'S LICENSE NO.	LAST NAME(S)	JR. ETC	FIRST NAME

HEIGHT		SEX	EYE COLOR	DATE OF BIRTH			TELEPHONE NUMBER	SOCIAL SECURITY NUMBER
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

DATE OF EXAMINATION: _____

How long have you been treating the patient? _____

SECTION B

DIAGNOSIS OF DISORDER OR DISABILITY: *Please Check (✔) Appropriate Items*

- ❑ Loss or Impairment of a Foot, Leg, Finger, Thumb, or Hand - Condition: _____
- ❑ Diabetes Mellitus
- ❑ Cerebral Vascular Disease
- ❑ Cardiovascular Disease
- ❑ Loss of Consciousness - Cause: _____
- ❑ Neurological Disorder
- ❑ Neuromuscular Disorder: _____
- ❑ Single Seizure: Date of Seizure: _____
- ❑ Seizure Disorder: ❑ YES ❑ NO Date of Last Seizure: _____
- ❑ Cognitive impairment: _____
- ❑ Neuropsychiatric Disorder: _____
- ❑ Psychiatric Disorder: _____
- ❑ Vision Deficiency: ❑ Acuity ❑ Visual Fields
- ❑ Other Medical Condition that would interfere with the patient's ability to drive. Explain: _____

NOTE: A seizure disorder- More than one seizure or a single seizure of electrically diagnosed epilepsy.

Patient meets following seizure waiver, therefore no action should be taken on the driving privilege:

- ❑ 2 year history of strictly a nocturnal pattern of seizures or a pattern of seizures occurring only immediately upon awakening
- ❑ 2 year history of a specific prolonged aura accompanied by sufficient warning
- ❑ Patient has been seizure free for the previous 6 months and above referenced seizure occurred as a result of a prescribed change in or removal from medication. Patient's previous medication has been reinstituted.
- ❑ Patient has been seizure free for previous 6 months and above referenced seizure occurred during or concurrent with a nonrecurring transient illness, toxic ingestion or metabolic imbalance.

Should this individual cease driving immediately? . . . . . ❑ YES ❑ NO

If not, does the condition(s) warrant further investigation of driving competency by the Department? . . . . . ❑ YES ❑ NO

SECTION C

Please indicate whether this person has any of the following:

Alcohol Use: ❑ Yes ❑ No Drug or Controlled Substance Use: ❑ Yes ❑ No

SECTION D

ALL INFORMATION IS CONFIDENTIAL AS PROVIDED IN THE PA VEHICLE CODE, SECTION 1518(d)

HEALTH CARE PROVIDER'S NAME	SPECIALTY	HEALTH CARE PROVIDER'S LICENSE NUMBER
Kandan Kulandaivel	Neurology	MD436179

STREET ADDRESS	CITY	STATE	ZIP CODE
1151 Old York Rd, 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

Return this form to the address listed at the top of the form or fax to (717) 705-4415
If Additional Information is Required, Please Feel Free to Call Us at: (717) 787-9662