REGISTRY OF MOTOR VEHICLES

Psychiatric Evaluation Form

Mail to: Driver Control Unit, PO Box 55889, Boston, MA 02205-5889
FAX: 857-368-0902 ● mass.gov/rmv

I hereby authorize the person completing this form to discuss and release any or all medical records pertaining to its content with or to representatives of the Registry of Motor Vehicles.

Applicant's Signature: _____ Date:_____

This form must be fully completed by a medical doctor who is licensed to practice in the Commonwealth of Massachusetts or a psychiatric nurse practitioner. It must be submitted by mail or fax to the Driver Control Unit.

A. Patient Information

Last Name	First Name	Middle Name	Suffix

Date of Birth (MM/DD/YYYY)	Driver's License #	Reported Condition

The Registry of Motor Vehicles has received information that the patient named above may have a condition which could affect his/her ability to operate a motor vehicle. Please complete the following so that the RMV can fairly evaluate the impact of your patient's condition upon his/her ability to operate a motor vehicle safely:

1. Please describe the patient's psychiatric condition, using DSM-V or ICD-10 diagnosis:

2. Please describe the extent, frequency, and control of the symptoms of the patient's condition or disability which may affect his/her ability to operate a motor vehicle (i.e., oriented in all spheres, dissociative episodes, etc.):

3. Is the patient's psychiatric condition or disability likely to interfere with his/her mental or physical ability to operate a motor vehicle safely? ..... ☐ Yes ☐ No

4. If condition involves seizure or any type of altered or loss of consciousness, please state type and date of last episode:

5. Is patient on any medication(s)? ☐ Yes ☐ No If Yes, please list medication(s) with dosage(s):

   Are these medications, separately or in combination, likely to interfere with his/her ability to operate a motor vehicle safely? ..... ☐ Yes ☐ No

6. Please check one of the following categories:
   I hereby certify that in my professional opinion and to a reasonable degree of medical certainty, one of the following:

   ☐ The patient named above is medically qualified to operate a motor vehicle safely.

   ☐ The patient named above is NOT medically qualified to operate a motor vehicle safely.

   ☐ I am unable to determine driving ability and recommend the patient undergo a competency road examination.

7. Please check one:
   I have read the attached police report and am aware of the reported incident involving my patient. ..... ☐ Yes ☐ No ☐ N/A

8. Additional Comments:

B. Physician Certification

Physician's /RN's Name	Phone #
National Provider Number (NPI #)	Massachusetts Board of Registration # (if you don't have an NPI #)

Address

Street City State ☐☐ Zip Code

I hereby certify, under the pains and penalties of perjury, that the information I have provided herein is true, accurate, and complete.

Certifying Signature: _____ Date: _____