Psychiatric Evaluation Form

Registry of Motor Vehicles ● Medical Affairs
P.O. Box 55889, Boston, MA 02205-5889
Phone: 857-368-8020 ● Fax: 857-368-0018

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 physician: a medical doctor who is licensed to practice in the Commonwealth of Massachusetts or a psychiatric nurse practitioner.

A. Patient Information

Last Name	First Name	Middle Name	Suffix

Date of Birth (MM/DD/YYYY)	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 Registry 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-IV 5-axis diagnosis:_____

   _____

   _____

   _____

2. Please describe the extent, frequency and control of the symptoms of the patient's condition or disability which may affect his or 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 #	Registration #

Address

Street City State Zip Code

Signature: _____ Date: _____