DR 2401 (03/13/24)
COLORADO DEPARTMENT OF REVENUE
Division of Motor Vehicles
P.O. Box 173350
Denver CO 80217-3350
FAX: (303) 205-8301

Confidential Medical Examination Report

Instruction Sheet

The Driver/Patient Section is to be completed by the Driver/Patient.

1. The Driver/Patient should fill in their Name, Address, Customer Identification Number, if known, and Date Of Birth.
2. The Driver/Patient should sign this section.

The Physician/Ophthalmologist section is to be completed by a Physician (MD or DO), Physicians Assistant (PA) or an Ophthalmologist/Optometrist (OD).

1. The form is valid for 180 days from the date of the examination.
2. If the 'Require DMV retesting in one year?' question is not answered, "No" will be assumed and selected as a default answer.
3. The Physician/Ophthalmologist observation section required fields must be completed.
4. Only ONE of the fitness to operate options must be selected.
5. Any alterations, erasures or multiple selections of the fitness to operate options will result in an invalid and rejected form.
6. The form must be signed by a Physician (MD or DO), Physicians Assistant (PA) or an Ophthalmologist/Optometrist (OD).
7. **Forms signed by a Nurse Practitioner (NP) will be rejected.**

If a DR 2401 is requested by the Department of Motor Vehicles, Drivers License Office, the examination date on the form needs to be after the issue date of the notice of cancellation and denial. The form is valid for 180 days from the date of the examination.

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Driver/Patient Section

Patient Last Name | First Name | Middle Initial

Street Address

City | State | ZIP Code

State: CO

Customer Identification Number (CIN) | Date of Birth

Driver Statement of Understanding (Driver signature not required for DMV processing):

- My physician will conduct a medical examination to determine my fitness to operate a motor vehicle safely and responsibly.
- My physician will respond to any additional questions from the Department of Motor Vehicle (DMV).
- I understand that this form will be considered in any decision regarding the issuance of my driver license, pursuant to C.R.S. 42-2-111 & 42-2-112.

Signature of Driver or Patient | Date (MM/DD/YY)

Driver/Patient (respond to all questions below before seeing your physician)

1. How many driving trips do you make in a typical week?.....

2. Do any of your regular trips involve driving at night?..... ◯ Yes ◯ No

3. What is the one-way distance of your furthest regular trip?..... Miles

4. Do any of your regular trips involve speeds ≥ 55 MPH?..... ◯ Yes ◯ No

5. Were you pulled over by a police officer in the past year?..... ◯ Yes ◯ No

6. Were you involved in a crash as a driver in the past year?..... ◯ Yes ◯ No

Physician Section

Instructions: use your best clinical judgment as you **Review and Complete All Sections.** Base severity ratings within each category on your overall assessment of impairment relative to the driving task. **Form must be completed by the Physician (MD or DO) or Physician's Assistant (PA)**. Pursuant to C.R.S. 42-2-112, no civil or criminal action shall be brought against a physician or physician assistant licensed in Colorado for providing a written medical opinion if the physician or physician assistant acts in good faith and without malice.

Examination Date (MM/DD/YY)

(Form is valid for 180 days from date of exam)

Are you the primary care provider for this patient? ○ Yes ○ No

If yes, how many times have you seen this patient in the past year?

If no, are you evaluating this patient for the first time today? ○ Yes ○ No

If no, have you reviewed the patient's medical records? ○ Yes ○ No

To your knowledge, is this patient:

Aware of his or her medical diagnosis & status? ○ Yes ○ Somewhat ○ No

Aware of functional impairments that may impact driving? ○ Yes ○ Somewhat ○ No

Compliant with medications & basic requirements of self-care? ○ Yes ○ Somewhat ○ No

Does this patient have:

Cardiovascular Disease ○ Yes ○ No

Cardiac Arrhythmia ○ Yes ○ No

Heart Failure ○ Yes ○ No

AHA Functional Capacity (check level if applicable): ○ N/A ○ I ○ II ○ III ○ IV

Require DMV retesting in one year? ○ Yes ◉ No

Current Medications

To your knowledge, is this patient subject to any consistent medicine side effects or interactions that may impair driving ability?

○ Yes ○ Possibly ○ Not Likely ○ No

Based on my observations of this patient and information relayed to me by this individual, I, reasonably and in good faith, believe that:

Patient Name

_____ is

Must Choose One:

- ◯ Fit to operate a motor vehicle safely.
- ◯ Fitness to drive determination pending; rehab permit required
- ◯ Fit to operate a motor vehicle safely contingent upon passing a DMV Road Test.
- ◉ **Not Fit** to operate a motor vehicle safely and responsibly due to significant medical-functional compromise or deficit.

Recommended license restriction(s):

- ☐ Daylight Driving Only
- ☐ Specialty Cushion
- ☐ Mile Radius Only _____
- ☐ No Highway/Freeway Driving
- ☐ Foot Device
- ☐ Hand Control
- ☐ Automatic Transmission Only
- ☐ Steering Device
- ☐ Restricted MPH _____
- ☐ Other _____
- ☐ Patient also requires an eye exam

Cognitive, Cerebrovascular or Neurological Condition is: ◯ Stable ◯ Progressive ◯ N/A

Mental Status (list test and score)

_____

- ☐ Confusion or Disorientation
- ☐ Memory Loss or Forgetfulness
- ☐ Inattention or Distractibility
- ☐ Impaired Judgment
- ☐ Visual-Spatial Deficit
- ☐ Slowed Processing Speed
- ☐ **Cognitive Impairment:**
  - ☐ Alzheimer's Disease
  - ☐ Vascular Dementia
  - ☐ Frontotemporal or Pick's
  - ☐ Dementia (other or unknown)
- ☐ **Cerebrovascular Disease:**
  - ☐ Cerebral Infarction or Stroke
  - ☐ Hemorrhage or Aneurysm
  - ☐ Transient Ischemic Attack
  - ☐ Carotid Occlusion or Hypoxia
- ☐ **Neurological Condition:**
  - ☐ Brain Injury (open or closed)
  - ☐ Tumor or Malformation
  - ☐ Parkinson's Disease
  - ☐ Multiple Sclerosis

Combined Impairment for Driving, Select Highest Level for Section.

- ◯ **Unimpaired** (Likely fit to Drive)
- ◯ **Very Mild** (Likely fit to Drive)
- ◯ **Mild** (Questionable Fitness)
- ◯ **Moderate** (Likely Unfit to Drive)
- ◯ **Severe** (Unfit to Drive)

Consciousness, Metabolic or Respiratory

Condition is: ○ Stable ○ Progressive ○ N/A

*Date of last event with impaired consciousness (MM/DD/YYYY):

☐ **Disorder of Consciousness or Alertness***

- ☐ Blackout or Syncope*
- ☐ Chronic Sleep Deprivation
- ☐ Sleep Apnea or Narcolepsy
- ☐ Epilepsy or Seizure Disorder
- ☐ Medication Effect
- ☐ Dizziness or Postural Hypotension

☐ **Metabolic Condition**

- ☐ Diabetes (Type 1 or 2)
- ☐ Thyroid Condition (Hypo or Hyper)
- ☐ Morbid Obesity or Fluid retention

☐ **Respiratory Condition**

- ☐ Asthma or shortness of Breath
- ☐ COPD
- ☐ Oxygen Dependent

Combined Impairment for Driving, Select Highest Level for Section.

○ **Unimpaired** (Likely fit to Drive) ○ **Very Mild** (Likely fit to Drive) ○ **Mild** (Questionable Fitness) ○ **Moderate** (Likely Unfit to Drive) ○ **Severe** (Unfit to Drive)

Musculoskeletal, Movement or Neuromuscular

Condition is: ○ Stable ○ Progressive ○ N/A

- ☐ Arthritis (Osteo or Rheumatoid)
- ☐ Frailty or General Weakness
- ☐ Motor Neuron Disease
- ☐ Orthopedic or Movement
- ☐ Uses Cane or Walker
- ☐ Paralysis - Arm
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Wheelchair Dependent
- ☐ Paralysis - Leg
- ☐ Restricted or Weakness - Arm
- ☐ Parkinson's Disease
- ☐ Difficulty Transferring
- ☐ Prosthesis or Brace - Arm
- ☐ Restricted or Weakness - Leg
- ☐ Loss of Limb
- ☐ Problems with Balance
- ☐ Prosthesis or Brace - Leg
- ☐ Restricted Neck Range of Motion
- ☐ History of Falls
- ☐ Other

Combined Impairment for Driving, Select Highest Level for Section.

○ **Unimpaired** (Likely fit to Drive) ○ **Very Mild** (Likely fit to Drive) ○ **Mild** (Questionable Fitness) ○ **Moderate** (Likely Unfit to Drive) ○ **Severe** (Unfit to Drive)

Psychiatric, Emotional or Addiction Condition is: ○ Stable ○ Progressive ○ N/A

☐ Depression ☐ Bipolar Mood Disorder ☐ Psychosis or Schizophrenia ☐ Alcohol Abuse or Addiction

☐ Drug Abuse or Addition ☐ Suicidal or Homicidal ☐ Anxiety or Post-Traumatic Stress ☐ Chronic Pain (causing distress)

☐ Other

Combined Impairment for Driving, Select Highest Level for Section.

○ **Unimpaired** (Likely fit to Drive) ○ **Very Mild** (Likely fit to Drive) ○ **Mild** (Questionable Fitness) ○ **Moderate** (Likely Unfit to Drive) ○ **Severe** (Unfit to Drive)

Specialty (Required) License Number (Required) Phone Number (Required)

Street Address

City State ZIP Code

Patient Last Name First Name Middle Initial

Physician Name (Printed)

Signature (Required) Date (MM/DD/YY)