

**DEPARTMENT OF TRANSPORTATION (DOT) COMMERCIAL DRIVER FITNESS DETERMINATION
COUMADIN**

Patient Name _____ Date _____

The above-named individual has presented to MedCentral for a Commercial Driver Fitness Determination in accordance with DOT regulations 49 CFR 391.41. During the examination it was noted that the individual is currently receiving COUMADIN therapy.

DOT guidelines: Part 391 of the Federal Motor Carrier Safety Regulations has been designed to protect both the health and safety of the driver and the general public. 1.) A driver on coumadin should be educated about the potential interactions of coumadin with other medications and diet, the increased risk of bleeding with trauma and the need for regular monitoring of coumadin's effect. 2.) The medical certification of commercial drivers with cerebrovascular disease and who are on coumadin is not recommended because of the increased risk of intracranial hemorrhage with sudden loss of consciousness.

Patient Consent for Release of Medical Information

I, _____ hereby authorize the release of all medical records and reports, including INR results, diagnostic imaging, laboratory reports, or other pertinent studies to MedCentral for Commercial Driver Fitness Determination.

Patient Signature _____ DOB _____

Witness _____ Date _____

Statement of Personal Physician

I have read and understand the DOT guidelines cited above. I verify that the above named individual has been educated about the potential interactions of coumadin with other medications and diet, the increased risk of bleeding with trauma and the need for regular monitoring of coumadin's effect. Also the condition and medications at the clinical dose will not cause imminent risk of syncopal episode or other symptoms that would affect the individual's ability to safely operate a commercial motor vehicle. **I am enclosing appropriate documentation, if applicable, to support this statement. Please include a copy of the most recent INR value.**

Physician Name _____ Date _____

Physician Signature _____

Street _____

City _____ State _____ Zip _____

Phone(_____) _____ Fax(_____) _____

PLEASE BRING THIS FORM AND SUPPORTING DOCUMENTS TO YOUR APPOINTMENT. THANK YOU FOR YOUR COOPERATION.

MedCentral West
1720 Westchester Dr.
High Point, NC 27262
Phone: (336) 883-4296
Fax: (336) 883-2615

MedCentral Thomasville
711 National Highway, Suite 100
Thomasville, NC 27360
Phone: (336) 885-9030
Fax: (336) 472-9215

MedCentral North
2401 Hickwood Rd., Suite 106
High Point, NC 27265
Phone: (336) 885-9675
Fax: (336) 885-9682