Australian Government
Civil Aviation Safety Authority

Form
166A

Driver Licence Medical Questionnaire (Aviation)

Patient Name	ARN
Address	

Please answer the questions by ticking the correct box. If you are not sure, leave the question blank and ask your doctor what it means. The doctor will ask you additional questions during the examination.

		No	Yes
1.	Are you currently being treated by a doctor for any illness or injury?	☐	☐
2.	Are you receiving any medical treatment or taking any medication - either prescribed or otherwise? (Please take any medications with you to show the doctor).	☐	☐
3.	Have you ever had, or been told by a doctor that you had any of the following?		
3.1	High blood pressure	☐	☐
3.2	Heart disease	☐	☐
3.3	Chest pain, angina	☐	☐
3.4	Any condition requiring heart surgery	☐	☐
3.5	Palpitations/irregular heartbeat	☐	☐
3.6	Abnormal shortness of breath	☐	☐
3.7	Head injury, spinal injury	☐	☐
3.8	Seizures, fits, convulsions, epilepsy	☐	☐
3.9	Blackouts, fainting	☐	☐
3.10	Stroke	☐	☐
3.11	Dizziness, vertigo, problems with balance	☐	☐
3.12	Double vision, difficulty seeing	☐	☐
3.13	Colour blindness	☐	☐
3.14	Kidney disease	☐	☐
3.15	Diabetes	☐	☐
3.16	Neck, back or limb disorders	☐	☐
3.17	Hearing loss or deafness or had an ear operation or use a hearing aid	☐	☐
3.18	Do you have difficulty hearing people on the telephone (including use of hearing aid if worn)?	☐	☐
3.19	Have you ever been told by a doctor that you had a psychiatric illness, or nervous disorder?	☐	☐
3.20	Have you ever had any other serious injury, illness, operation, or been in hospital for any reason?	☐	☐
4.1	Have you ever had, or been told by a doctor that you had a sleep disorder, sleep apnoea, or narcolepsy?	☐	☐
4.2	Has anyone noticed that your breathing stops or is disrupted by episodes of choking during your sleep?	☐	☐

4.3 How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:
0 = would never doze off
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing
It is important that you put a number [0 to 3] in each of the 8 boxes

Situation - Chance of dozing	**[0–3]**
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (e.g. a theatre or meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in the traffic	

5. *Please tick the answer that is correct for you:*

5.1 How often do you have a drink containing alcohol?

- ☐ Never
- ☐ Monthly
- ☐ Two to four times a month
- ☐ Two to three times a week
- ☐ Four or more times a week

5.2 How many drinks containing alcohol do you have on a typical day when you are drinking?

☐ 1 or 2 ☐ 3 to 5 ☐ 5 to 6 ☐ 7 to 9 ☐ 10 or more

5.3 How often do you have six or more drinks on one occasion?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

5.4 How often during the last year have you found that you were not able to stop drinking once you had started?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

5.5 How often during the last year have you failed to do what was normally expected from you because of drinking?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

5.6 How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

5.7 How often during the last year have you had a feeling of guilt or remorse after drinking?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

5.8 How often during the last year have you been unable to remember what happened the night before because you had been drinking?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

5.9 Have you or someone else been injured as a result of your drinking?

☐ No ☐ Yes, but not in the last year ☐ Yes, during the last year

5.10 Has a relative or friend or a doctor or other health worker been concerned about your drinking or suggested you cut down?

☐ No ☐ Yes, but not in the last year ☐ Yes, during the last year

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		No	Yes
6.	Do you use illicit drugs?	☐	☐
7.	Do you use any drugs or medications not prescribed for you by a doctor?	☐	☐
8.	Have you been involved in a motor vehicle or aircraft accident in the past two years?	☐	☐

If Yes, please give details:

Patient's Declaration (in presence of health professional):

I,_____

(Print Name)

certify that to the best of my knowledge the above information supplied by me is true and correct.

Patient (Signature): Date: | |

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Form
166B

Medical Practitioner Clinical Examination Proforma

Patient Name	ARN
Address	

The medical practitioner will be guided by findings in the patient questionnaire and may apply appropriate tests other than those outlined here, e.g. Mini Mental State or equivalent for cognitive conditions. This form (166B) is to be returned to the applicant by the examining health professional. Findings relevant to the person's fitness must be recorded on the Driver Licence Medical Certificate (Aviation) (Form 166C) supplied by CASA.

1. Cardiovascular System:

1.1 Blood Pressure (repeat if necessary)

Systolic	mm Hg	mm Hg
Diastolic	mm Hg	mm Hg

1.2 Pulse Rate: Regular ☐ Irregular ☐

1.3 Heart Sounds: Normal ☐ Abnormal ☐

1.4 Peripheral Pulses Normal ☐ Abnormal ☐

2. Chest/Lungs: Normal ☐ Abnormal ☐

3. Abdomen (liver): Normal ☐ Abnormal ☐

4. Neurological/Locomotor:

4.1 Cervical Spine Rotation Normal ☐ Abnormal ☐

4.2 Back Movement Normal ☐ Abnormal ☐

4.3 Upper Limbs
(a) Appearance Normal ☐ Abnormal ☐
(b) Joint movements Normal ☐ Abnormal ☐

4.4 Lower Limbs
(a) Appearance Normal ☐ Abnormal ☐
(b) Joint movements Normal ☐ Abnormal ☐

4.5 Reflexes Normal ☐ Abnormal ☐

*4.6 Romberg's Sign** Normal ☐ Abnormal ☐

(*A pass requires the ability to maintain balance while standing with shoes off, feet together side by side, eyes closed and arms by sides, for thirty seconds).

5. Vision:

5.1 Visual Acuity

Uncorrected		Corrected	
R	L	R	L
6/	6/	6/	6/

Are contact lenses worn? No ☐ Yes ☐

5.2 Visual Fields (Confrontation to each eye): Normal ☐ Abnormal ☐

6. Hearing Normal ☐ Abnormal ☐

7. Urinalysis

7.1 Protein Normal ☐ Abnormal ☐

7.2 Glucose Normal ☐ Abnormal ☐

8. Neuropsychological Assessment

Where clinically indicated apply the Mini Mental State Questionnaire or General Health Questionnaire or equivalent.

Score

RELEVANT CLINICAL FINDINGS

Comment here on relevant findings from the questionnaire or clinical examination, referring to:

(a) the unconditional private motor vehicle driver's licence medical standards contained in Austroads *Assessing fitness to drive for commercial and private vehicle drivers: medical standards for licensing and clinical management guidelines*, March 2012, or later version; and

(b) the disqualifying medical conditions listed in the CASA *Guidance for GPs Assessing Persons for a Driver's Licence Medical Certificate (Aviation).*

Registered medical practitioner's details

Full Name:

Signature: Date: | |

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Civil Aviation Safety Authority

Form
166C

DRIVER LICENCE MEDICAL CERTIFICATE (AVIATION)

Only an unmodified version of this form can be submitted to CASA. The patient and the registered medical practitioner (the Doctor) should read CASA's *Guidance for GPs Assessing Persons for a DL Medical Certificate (Aviation),* available on CASA's website (Guidance for GPs).

▼ *Patient details:*

Family Name: Given Name:

Date of Birth: ARN:

Address:

Postal address (if different):

▼ Doctor's *Certification*

I **CERTIFY** that, using CASA's DL Medical Questionnaire (Aviation) and Medical Practitioner Clinical Examination Proforma from CASA's *Guidance for GPs,* I have examined the abovementioned patient in accordance with the *aviation fitness standards*, being the standards for an unconditional private motor vehicle driver's licence, as published by Austroads Inc..* and modified by CASA for excluded conditions as explained in CASA's Guidance for GPs.

I **CERTIFY** that, in my opinion, the patient:

1. **MEETS** the aviation fitness standards for issue of a driver's licence medical certificate (aviation); and
2. **DOES NOT** have any of the disqualifying conditions mentioned in CASA's *Guidance for GPs,* the absence of which was expressly determined by me.

▼ *Doctor's familiarity with patient* (delete if not applicable)

I was familiar with the patient's medical history over a period of years before issuing this medical certificate.

Tick if appropriate:

☐ The patient must wear corrective lenses at all times when using this certificate for aviation purposes.

Date of Examination: **Date certificate expires**:**

▼ *Patient's permission*

I, *(patient name)* consent to the doctor providing CASA with information about me relevant to this medical assessment of my aviation fitness.

Patient's signature _____ **Date:** _____

▼ *Doctor's details*

Full Name: **Provider No.**

Practice address:

Postal address (if different):

Email Address:

▼ *Doctor's signature* _____ **Date:** _____

*The Austroads Inc. publication A*ssessing fitness to drive for commercial and private vehicle drivers: medical standards for licensing and clinical management guidelines*, being the version in force at the date this certificate was issued.

**For a person aged under 65 years — not exceeding 2 years. For a person aged 65 years or over — not exceeding 1 year.