Bradley K. Harrison MD, FAAFP

Kyle E. Platz DO, FAAFP

DEPARTMENT OF TRANSPORTATION (DOT) COMMERCIAL DRIVER FITNESS DETERMINATION
Anticoagulation

Patient Name_____

The above-named individual has presented 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 Anticoagulation therapy such as Warfarin (Coumadin), Apixaban (Eliquis), Rivaroxaban (Xarelto), or Dabigatran (Pradaxa).

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 anticoagulation should be educated about the potential interactions 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 anticoagulation 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 pertinent medical records and reports to Manhattan Primary Care for Commercial Driver Fitness Determination.

Patient Signature_____ DOB _____

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 anticoagulation therapy with other medications and diet, the increased risk of bleeding with trauma. I attest that he patient is compliant with monthly INRs (required by FMCSA) and that the patient has not on anticoagulation due to a cerebral vascular disorder such as history of stroke. 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 if on Coumadin, his indication for anticoagulation, length of treatment, and report he is compliant with monthly INR laboratory checks if appropriate.

Physician Name_____ Date _____

Physician Signature_____

Street_____

City_____ State_____ Zip_____

Phone (_____)_____ Fax (_____)_____

Please send this form and supporting documents to the address or fax listed below. Thank you for your help in obtain certification for this driver. If you have any questions, please contact Manhattan Primary Care.

Manhattan Primary Care
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