



# Fax Cover Sheet

Date 10-1-2022 Number of pages 6 (including cover page)

To:

Name BUREAU OF MOTORIST COMPLIANCE  
MEDICAL REVIEW PROGRAM

Company FLHSMV

Telephone 850-617-3814 (FAX 850-617-3944)

From:

Name Justina m. Russell

Company PERSONAL

Telephone 727-768-6547

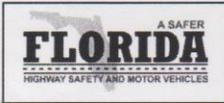
Comments MEDICAL REPORT FOR

Justina Russell

DL: R240-433-45-902-0



fedex.com 1.800.GoFedEx 1.800.463.3339



STATE OF FLORIDA  
DEPARTMENT OF HIGHWAY SAFETY  
AND MOTOR VEHICLES

MEDICAL REPORT

INSTRUCTIONS TO THE DRIVER: Please take this form to the physician most familiar with your medical history and the current status of your medical condition(s).

Name: Justina Russell Driver License #: R240-433-45-902-0

Date of Birth: 11-2-1945 Telephone #: 727-768-6547

INSTRUCTIONS TO THE PHYSICIAN: Please complete this form in its entirety. If a section does not apply, indicate "not applicable" or "N/A".

HISTORY:

- How long have you known this patient? \_\_\_\_\_ Date of last office visit? 8/5/2022
  - Other physicians the patient has seen in the past 2 years: Dr Phillip Christ 4/15/21
  - List any medical conditions or physical impairments the patient has: Hypertension, hyperlipidemia, back pain, polyarthralgia, depression, neuropathy
  - List all prescribed medications: Pericard 10-325, Meloxicam 15mg, gabapentin 300 twice a day, trazodone 50mg, once per day
5. Does the patient receive regular medical care? yes Is patient reliable in taking medications? yes

SECTION 1 - NEUROLOGICAL

Does the patient have a history of epilepsy or convulsive seizures? no

Date of last seizure of any type: n/a

Medication and dosage for prevention: n/a

Current anticonvulsant blood level: n/a Date taken: \_\_\_\_\_

If not in therapeutic range, please explain: \_\_\_\_\_

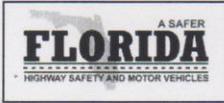
If medication discontinued, give date: \_\_\_\_\_ EEG? (Please attach a copy): \_\_\_\_\_

Please list any progressive neurological or neuromuscular disease: none

Please describe any physical activity limitations imposed by the condition: Pt has significant mobility problems in left shoulder and lower back pain

What is the status of the condition? pain is controlled FSS/EDSS? (Please attach a copy): \_\_\_\_\_

Please list any neurological deficits due to CVA's, closed head injury, etc.: N/A



STATE OF FLORIDA  
DEPARTMENT OF HIGHWAY SAFETY  
AND MOTOR VEHICLES

MEDICAL REPORT

SECTION 2 – LOSS OF CONSCIOUSNESS/DIZZINESS

Does the patient have a history of blackouts, fainting spells, or dizziness? NO

Possible cause: \_\_\_\_\_ Frequency: \_\_\_\_\_ Date of last episode: \_\_\_\_\_

SECTION 3 – PSYCHIATRIC

Has the patient ever been admitted to a hospital or treated for mental or emotional illness? not that I am aware of

Facility: \_\_\_\_\_ Date of admission: \_\_\_\_\_ Date discharged: aware of

Is the patient presently under treatment for, show evidence of, or have difficulty with any emotional problems or mental illness? Depression If yes, please attach a psychiatric report. - N/A

What is the status of the condition? controlled/managed with medication

SECTION 4 – MENTAL/COGNITIVE

Is there any evidence of memory loss? yes Any evidence of organic brain syndrome? yes

Any history of frequent or intermittent confusion? NO

If there are any cognitive deficits noted above, please provide the results of a Mini Mental State Exam (MMSE) or a Montreal Cognitive Assessment (MoCA): MMSE score within normal 28

Education level of patient: \_\_\_\_\_

SECTION 5 – ALCOHOL AND DRUG

Is there any evidence or personal knowledge of addiction or abuse of alcohol or other drugs? no

When and where has patient been treated for alcoholism or drug dependency: no

Does the patient consume alcohol or drugs at this time? no To what extent? \_\_\_\_\_

If not, how long has the patient been alcohol and/or drug free: N/A

SECTION 6 – DIABETES

What type of diabetes does the patient have? N/A

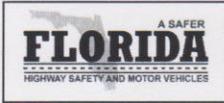
How many times has patient been in diabetic ketoacidosis? \_\_\_\_\_ Date of last episode: \_\_\_\_\_

Frequency of hypoglycemic episodes involving LOC or near LOC: \_\_\_\_\_ Date of last episode: \_\_\_\_\_

How frequently have you seen this patient for control of patient's diabetes? \_\_\_\_\_

The physician's assessment of the control of the patient's diabetes: \_\_\_\_\_

If uncontrolled, please explain: \_\_\_\_\_



STATE OF FLORIDA  
DEPARTMENT OF HIGHWAY SAFETY  
AND MOTOR VEHICLES

MEDICAL REPORT

SECTION 7 - CARDIAC

Please describe any cardiac problem the patient has that could interfere with driving: none n/a

Please provide date of last episode of any LOC related to cardiac abnormalities or arrhythmias: n/a

Please describe any treatment the patient is receiving: n/a

What is the status of the condition? n/a

SECTION 8 - MUSCULOSKELETAL

Explain any limitation of motion, weakness, spasticity, or paralysis: left shoulder reduced mobility and weakness

What is the status of the condition? For L shoulder healed

Would adaptive equipment assist the patient with driving? no If yes, please describe: \_\_\_\_\_

Has the patient completed a recent Certified Driver Evaluation (CDE)? unknown If yes, please attach copy.

SECTION 9 - SLEEP DISORDER

Please describe the frequency, severity, and treatment of the following sleep disorders: sleep apnea, narcolepsy, or insomnia: insomnia - managed with trazodone

What is the status of the condition? controlled

SECTION 10 - VISUAL

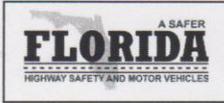
Visual acuity - Name of equipment used: \_\_\_\_\_

Without glasses: RE 20/ 40 LE 20/ 60 BE 20/ 40

With glasses: RE 20/ 30 LE 20/ 40 BE 20/ 30

Field of vision: RE 140 LE 140 BE 160

Does the patient use prism lenses to compensate for visual field loss? No



STATE OF FLORIDA  
DEPARTMENT OF HIGHWAY SAFETY  
AND MOTOR VEHICLES

MEDICAL REPORT

PHSYCIAN'S RECOMMENDATION

Dear Doctor: The Department's Medical Advisory Board is charged with determining this individual's physical and mental ability to safely operate a motor vehicle. The information provided by you is vital in making this determination. In addition, we would like you to provide your opinion below as to whether or not this individual can operate a motor vehicle safely. This will be taken into consideration when rendering a decision in this case.

PLEASE ANSWER "YES" OR "NO" HERE: \_\_\_\_\_ PLEASE EXPLAIN YOUR ANSWER:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Mail this Completed Form to:  
Bureau of Motorist Compliance  
Medical Review Program  
Neil Kirkman Building, MS 86  
Tallahassee, Florida 32399-0500  
Telephone No.: (850) 617-3814  
Fax No.: (850) 617-3944

Signature of Physician: \_\_\_\_\_

Print Physician's Name: \_\_\_\_\_

Augusta B Stah

Medical License #: \_\_\_\_\_

NA 10056

Classification or Specialty: \_\_\_\_\_

Internal Medicine

Address: \_\_\_\_\_

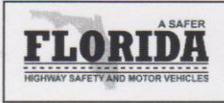
13220 Becker road Hill 1040 FL 33733

Telephone Number: \_\_\_\_\_

727 533 2242

Date: \_\_\_\_\_

09/19/2002



STATE OF FLORIDA  
DEPARTMENT OF HIGHWAY SAFETY  
AND MOTOR VEHICLES

MEDICAL REPORT

PHSYCIAN'S RECOMMENDATION

Dear Doctor: The Department's Medical Advisory Board is charged with determining this individual's physical and mental ability to safely operate a motor vehicle. The information provided by you is vital in making this determination. In addition, we would like you to provide your opinion below as to whether or not this individual can operate a motor vehicle safely. This will be taken into consideration when rendering a decision in this case.

PLEASE ANSWER "YES" OR "NO" HERE: \_\_\_\_\_ PLEASE EXPLAIN YOUR ANSWER:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Mail this Completed Form to:  
Bureau of Motorist Compliance  
Medical Review Program  
Neil Kirkman Building, MS 86  
Tallahassee, Florida 32399-0500  
Telephone No.: (850) 617-3814  
Fax No.: (850) 617-3944

Signature of Physician: [Signature]

Print Physician's Name: ANGELA B STAN

Medical License #: NR 10056

Classification or Specialty: INTERNAL MEDICINE

Address: 13220 Baker road Hill Lake FL 33733

Telephone Number: 727 533 2242

Date: 09/19/2002

**APURVA SHAH, MD, MPH**  
 LIC # ME100562  
**PATRICIA MARIE HATTON**  
 APRNT1011912  
 13220 BELCHER RD., SUITE 11  
 LARGO, FL 33773  
 Phone: (727) 533-2242  
 Fax: (727) 533-2252

DEA # \_\_\_\_\_  
 NAME Justina Russell DOB 11/11/21  
 ADDRESS \_\_\_\_\_ DATE 11-11-21  
RX IS ILLEGAL IF NOT SAFETY BLUE BACKGROUND  
 RESISTS ERASURES AND ALTERATIONS  
 \*VOID\* APPEARS IF COPIED

**R** Justina scored well on  
 a memory cognitive exam

Label Refill NR 1 2 3 4 5  
 \_\_\_\_\_  
 (Signature)

In order for the brand name product to be dispensed the prescriber must write "Medically Necessary" on the front of this prescription.

SSH21070255065



To: 850-617-3944  
 Date: 10/1/2022  
 Started: 12:32 PM  
 Ended: 12:33 PM  
 Originals: 6  
 Sent: 6

Fax Confirmation Report

**Robson Eye Institute**  
 35111 U.S. Highway 19 North, #100  
 Palm Harbor, FL 34684  
 Tel: (727) 266-2393  
 Fax: (727) 266-2330

**Jordan Johnson, OD**  
 Lic # OPC5588  
 NPI # 1194207662

NAME: RUSSELL, JUSTINA

DOB: 11/02/1945  
 RX DATE: 09/26/2022

**R** Spectacles  
 Sphere Cylinder Axis ADD V Prism H Prism  
 OD +1.50 -0.75 110 +2.25  
 OS +1.25 -0.50 55 +2.25  
 Prism Type: /

Remarks: Total Items: 1 Electronically Generated Signature

Control #4289-637997979605072804

*Justina Russell*  
 Signed

**Appointment**

For: Robson Eye Institute  
 Date: (Humphrey Visual Field  
 Time: Machine for Field of  
Vision) 727-266-2393

If you are unable to keep your appointment, please contact us as soon as possible.

**APURVA SHAH, MD, MPH**  
 LIC # ME100562  
**PATRICIA MARIE HATTON**  
 APRNT1011912  
 13220 BELCHER RD., SUITE 11  
 LARGO, FL 33773  
 Phone: (727) 533-2242  
 Fax: (727) 533-2252

DEA # \_\_\_\_\_  
 NAME Justina Russell DOB 11/11/21  
 ADDRESS \_\_\_\_\_ DATE 11-11-21  
RX IS ILLEGAL IF NOT SAFETY BLUE BACKGROUND  
 RESISTS ERASURES AND ALTERATIONS  
 \*VOID\* APPEARS IF COPIED

**R** Justina scored well on  
 a memory cognitive exam

Label Refill NR 1 2 3 4 5  
 \_\_\_\_\_  
 (Signature)

In order for the brand name product to be dispensed the prescriber must write "Medically Necessary" on the front of this prescription.

SSHE1070255065



To: 850-617-3944  
 Date: 10/1/2022  
 Started: 12:32 PM  
 Ended: 12:33 PM  
 Originals: 6  
 Sent: 6

Fax Confirmation Report

**Robson Eye Institute**  
 35111 U.S. Highway 19 North, #100  
 Palm Harbor, FL 34684  
 Tel: (727) 266-2393  
 Fax: (727) 266-2330

**Jordan Johnson, OD**  
 Lic # OPC5588  
 NPI # 1194207662

NAME: RUSSELL, JUSTINA  
 DOB: 11/02/1945  
 RX DATE: 09/26/2022

**R** Spectacles  
 Sphere Cylinder Axis ADD V Prism H Prism  
 OD +1.50 -0.75 110 +2.25  
 OS +1.25 -0.50 55 +2.25  
 Prism Type: /

EXPIRES: 1 YEAR

Remarks: Total Items: 1 Electronically Generated Signature

Control #4289-637997979605072804

*Justina Russell*  
 Signed

**Appointment**

For: Robson Eye Institute  
 Date: (Humphrey Visual Field  
 Time: Machine for Field of  
Vision) 727-266-2393

If you are unable to keep your appointment, please contact us as soon as possible.