



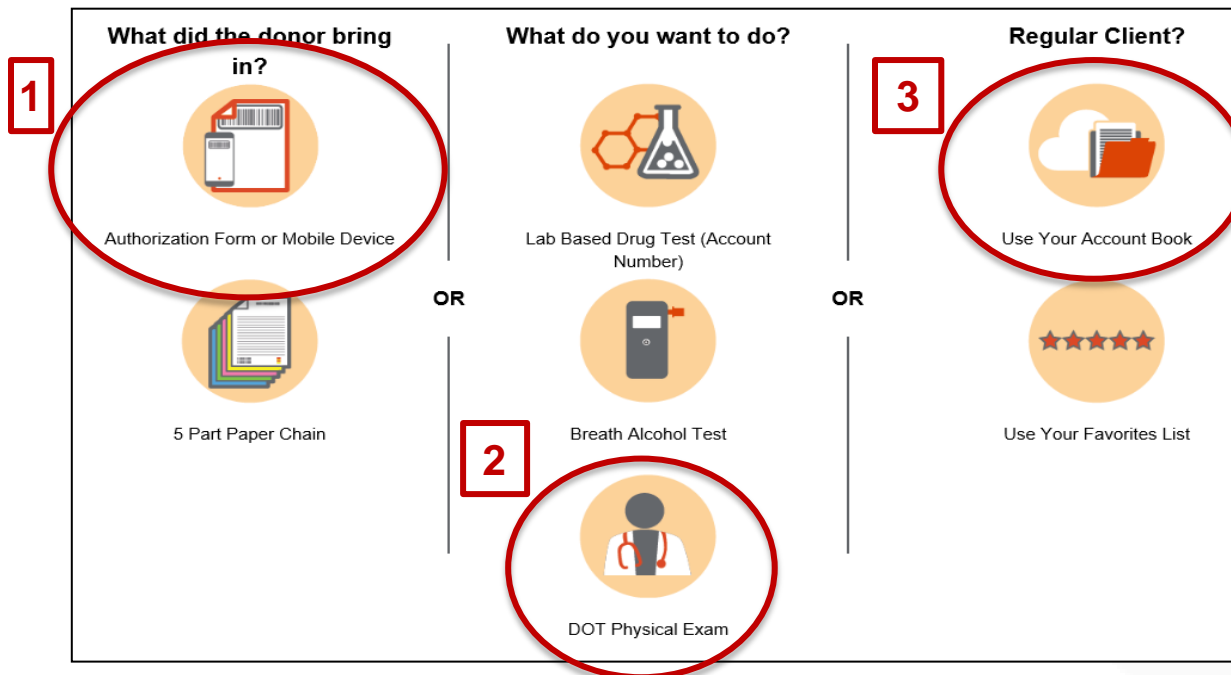
Workflow Solutions
Simple, Secure, Fast

FormFox DOT Physical Exam
Step-by-Step Guide for
MSS STAFF

Beginning a DOT ePhysical on FormFox

There are three ways to begin a DOT ePhysical on FormFox.

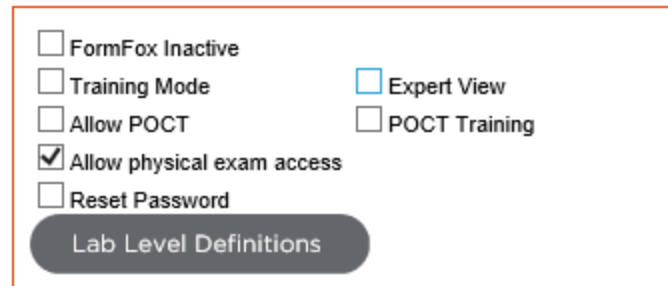
1. If the driver arrives with a printed authorization form or with the authorization barcode on a mobile device, use the 'Authorization Form or Mobile Device' button.
2. If the driver doesn't have an authorization form/barcode, you can begin an exam from scratch using the DOT Physical Exam button.
3. If you've set up the driver's employer in your Account Book, you can use the Account Book button to begin the exam.



Important Note for MSS Logins

If you are unable to complete the Information, Health History, and Vitals tabs due to the software kicking you out of the DOT Exam workflow, please contact your FormFox Administrator.

In order to access the DOT Exam using your collector/administrator login, you must have 'Allow physical exam access' enabled in your user details.



A screenshot of a user settings form with a red border. It contains several checkboxes and a button. The checkboxes are: 'FormFox Inactive', 'Training Mode', 'Allow POCT', 'Allow physical exam access' (checked), and 'Reset Password'. To the right of these are 'Expert View' and 'POCT Training'. At the bottom is a dark grey button labeled 'Lab Level Definitions'.

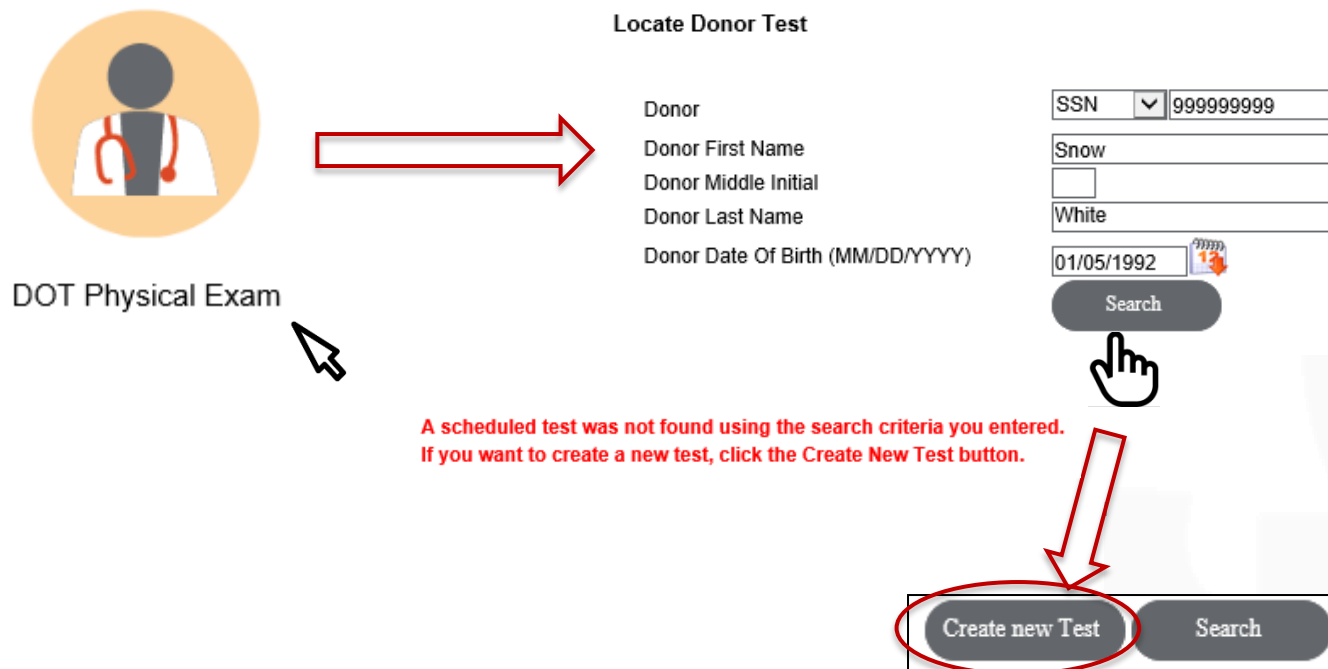
<input type="checkbox"/> FormFox Inactive	
<input type="checkbox"/> Training Mode	<input type="checkbox"/> Expert View
<input type="checkbox"/> Allow POCT	<input type="checkbox"/> POCT Training
<input checked="" type="checkbox"/> Allow physical exam access	
<input type="checkbox"/> Reset Password	

Lab Level Definitions

Demo: 'DOT Physical Exam' Button

Click on the 'DOT Physical Exam' button on the home page and enter the donor's information on the next page. Click 'Search.' FormFox will search the system for any pre-ordered exams before showing the 'Create new Test' button.

Click 'Create new Test' to begin the DOT Physical Exam.



The screenshot shows a 'Locate Donor Test' form with the following fields: Donor (dropdown), Donor First Name (text), Donor Middle Initial (text), Donor Last Name (text), and Donor Date Of Birth (MM/DD/YYYY) (calendar). The values entered are SSN: 999999999, First Name: Snow, Last Name: White, and Date of Birth: 01/05/1992. A 'Search' button is located below the date field. A red arrow points from a 'DOT Physical Exam' button (represented by a doctor icon) to the form. Another red arrow points from the 'Search' button to a 'Create new Test' button, which is circled in red. A red error message is displayed below the form: 'A scheduled test was not found using the search criteria you entered. If you want to create a new test, click the Create New Test button.'

Locate Donor Test

Donor

Donor First Name

Donor Middle Initial

Donor Last Name

Donor Date Of Birth (MM/DD/YYYY)

**A scheduled test was not found using the search criteria you entered.
If you want to create a new test, click the Create New Test button.**

Demo: 'DOT Physical Exam' Button

DOT Physical Exam

Information History

Fields marked with an asterisk (*) are required.

* First Name: * Last Name: Middle:

* Date of Birth (MM/DD/YYYY): * Sex: Male Female

* Home Phone: * Work Phone:

* Home Address:

* City: * State: * Zip:

* Driver License #: * State of Issue:

E-mail (optional):

* CLP/CDL Applicant/Holder? Yes No * Driver ID Verified By:

* Has your USDOT/FMCSA medical certificate ever been denied or issued for less than 2 years? Yes No Not Sure

* Have you ever had surgery? Yes No Not Sure
If "yes", please list and explain below.

* Are you currently taking medications (prescription, over-the-counter, herbal remedies, diet supplements)? Yes No Not Sure
If "yes", please describe below.

Close Submit

Complete the Information and History Tabs with the driver.

Click 'Submit' on both tabs to save the entered data.

DOT Physical Exam

formfox Driver (Patient): Snow White

Information History

Fields marked with an asterisk (*) are required.

Do you have or have you ever had:

Not		Not	
Yes	No	Yes	No
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
1. Head/Brain injuries or illnesses (e.g., concussion)		16. Dizziness, headaches, numbness tingling, or memory loss	
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Seizures, epilepsy		17. Unexplained weight loss	
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Eye problems (except glasses or contacts)		18. Stroke, mini-stroke (TIA), paralysis, or weakness	
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Ear and/or hearing problems		19. Missing or limited use of arm, hand, finger, leg, foot, toe	
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Heart disease, heart attack, bypass, or other heart problems		20. Neck or back problems	
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Pacemaker, stents, implantable devices, or other heart procedures		21. Bone, muscle, joint, or nerve problems	
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. High blood pressure		22. Blood clots or bleeding problems	
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. High cholesterol		23. Cancer	
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Chronic (long-term) cough, shortness of breath, or other breathing problems		24. Chronic (long-term) infection or other chronic diseases	
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. Lung disease (e.g., asthma)		25. Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring	
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
11. Kidney problems, kidney stones, or pain/problems with urination		26. Have you ever had a sleep test (e.g., sleep apnea)?	
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
12. Stomach, liver, or digestive problems		27. Have you ever spent a night in the hospital?	
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
13. Diabetes or blood sugar problems		28. Have you ever had a broken bone?	
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
14. Anxiety, depression, nervousness, other mental health problems		29. Have you ever used or do you now use tobacco?	
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
15. Fainting or passing out		30. Do you currently drink alcohol?	
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
		31. Have you used an illegal substance within the past two years?	
		<input type="checkbox"/>	<input checked="" type="checkbox"/>
		32. Have you ever failed a drug test or been dependent on an illegal substance?	
		<input type="checkbox"/>	<input checked="" type="checkbox"/>

* Other Health Condition(s) not described above Yes No

You answered "YES" to a question(s). Please comment further on those health conditions

Q14 - Depression for 15 years. Currently taking 75 mg of Venlafaxine once daily.

Medical Examiner's Comments

Review and discuss pertinent driver answers and any available medical records. Comment on the driver's responses to the "health history" questions that may affect the driver's safe operation of a commercial motor vehicle (CMV).

Patient Signature

Close Suspend Submit

Answering 'Yes' or 'Not Sure'

If the driver answers 'Yes' or 'Not Sure,' the exam wizard will require them to provide further explanation.



You have answered Yes and need to provide further explanation. Please include Onset Date, Diagnosis. **List all medications** (including over-the-counter medications) used recently.

Cancel

Submit



THIS IS A FEDERAL EXAM

Filling Out the 'Vitals' Tabs

Medical Support Staff can complete these four tabs in any order. Please make sure to click 'submit' to save the entered data within each section.

A section will turn **green** once complete. If there is information on the tab that requires attention from the Provider, the tab will turn **orange**.



Weight & Vision

The 'Weight & Vision' tab will be completed by the MSS Staff. Click 'Submit' to continue.

DOT Physical Exam

Information History

WEIGHT & VISION

Fields marked with an asterisk (*) are required.

* Height:(in) * Weight:(lbs) BMI: 19.1 Neck Circumference:(Inches)

ACUITY

	Uncorrected	Corrected	Horizontal Field of Vision
* Right Eye 20 /	<input type="text"/>	20 / <input type="text" value="20"/>	* Right Eye <input type="text" value="70"/> degrees
* Left Eye 20 /	<input type="text"/>	20 / <input type="text" value="20"/>	* Left Eye <input type="text" value="70"/> degrees
* Both Eyes 20 /	<input type="text"/>	20 / <input type="text" value="20"/>	

* Applicant can recognize and distinguish among traffic control signals and devices showing red, green, and amber colors Yes No

* Monocular Vision Yes No

* Referred to ophthalmologist or optometrist? Yes No

* Received documentation from ophthalmologist or optometrist? Yes No

Close

Suspend

Submit

Hearing

The MSS Staff will also complete the 'Hearing' section. Click 'Submit' to continue.

Information

History

HEARING

Check if hearing aid used for test: Right Ear Left Ear Neither

Numerical Readings must be recorded

Record distance from individual
at which a forced whispered voice can first be heard

Right Ear	Left Ear
<input type="text" value="5"/> / Feet	<input type="text" value="5"/> / Feet

OR

If audiometer is used, record hearing loss in decibels

Right Ear			Left Ear		
500Hz	1000Hz	2000Hz	500Hz	1000Hz	2000Hz
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Average: 0			Average: 0		

Close

Suspend

Submit

BP & Pulse

'BP & Pulse' will also be completed by the MSS Staff. Click 'Submit' to continue.

Information History

BP & PULSE

Fields marked with an asterisk (*) are required.
Numerical Readings must be recorded. Medical Examiner should take at least two readings to confirm BP.

* Blood Pressure ^{* Systolic} ^{* Diastolic}

* Pulse rhythm regular? Yes No

* Record Pulse Rate

Second Reading (Optional)

Blood Pressure ^{Systolic} ^{Diastolic}

Other testing if indicated

Close Suspend **Submit**

Lab

The 'Lab' Tab is also completed by the MSS Staff. Select 'Submit' to continue.

Information History

LAB

Fields marked with an asterisk (*) are required.
Numerical Readings must be recorded.

Urine Specimen

* Sp. Gr. * Protein * Blood * Sugar Glucose Meter Measurements (mg/dl)

Place Exam on Hold pending further testing. Uncheck when lab results have been entered in the comments section below.

Urinalysis is required. Protein, blood or sugar in the urine may be an indication for further testing to rule out any underlying medical problem.

Other Testing describe and record

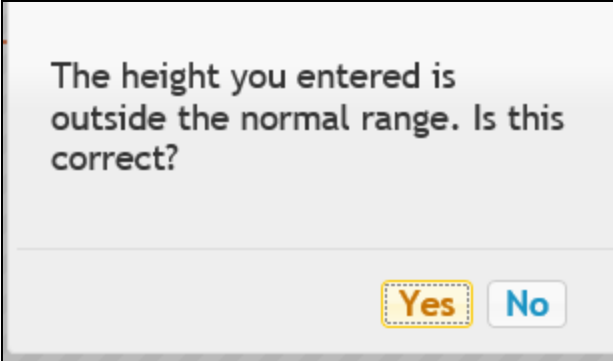
Close

Suspend

Submit

FormFox Validations

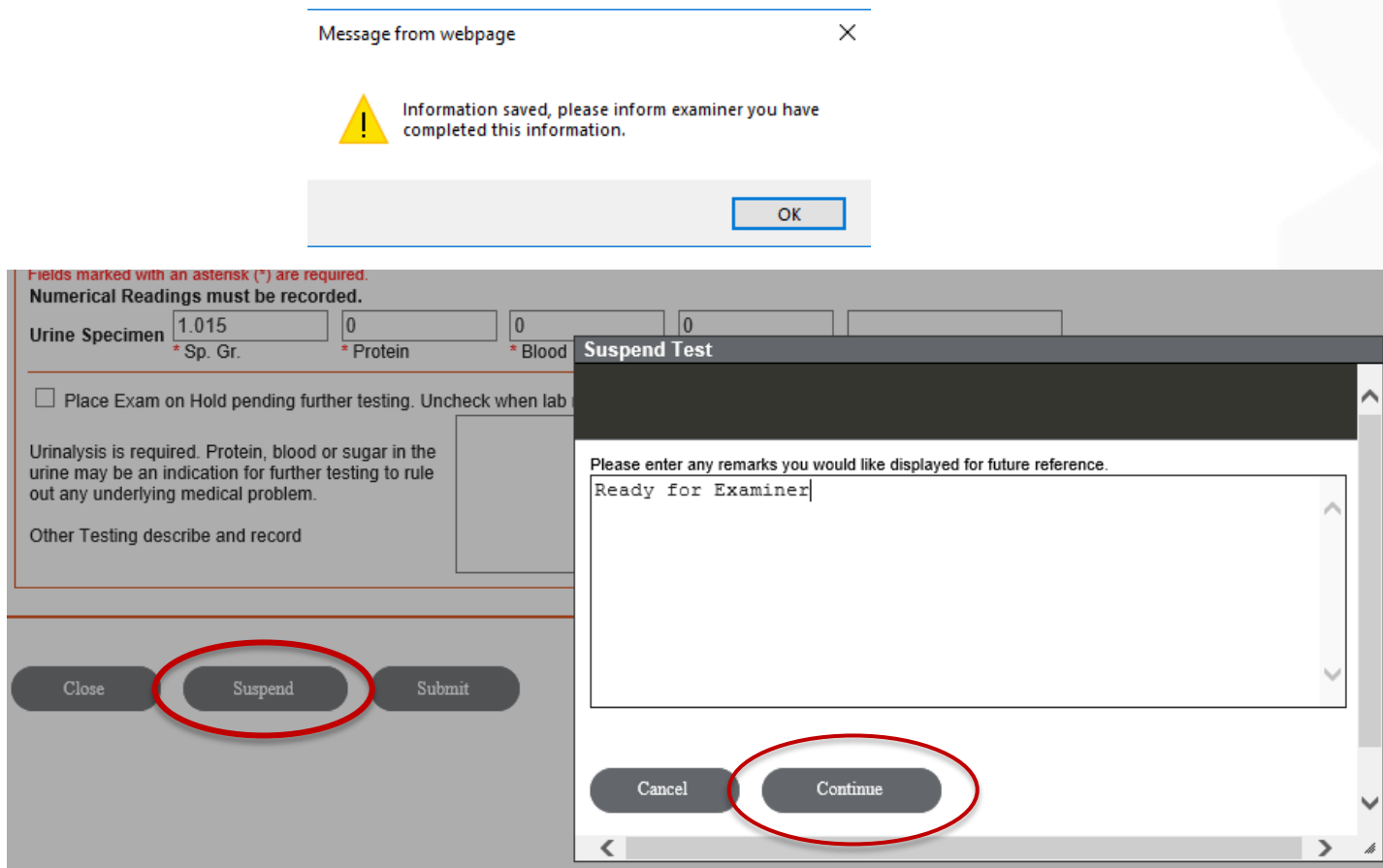
If a value is entered that is considered outside the normal range, FormFox will ask the collector to indicate if the data entered is correct via a pop-up window. If the collector selects 'Yes,' he/she can continue to move forward in the wizard. If the collector selects 'No,' he/she will be able to edit the entered information.




The height you entered is outside the normal range. Is this correct?

Suspending the Test (MSS)

MSS Staff will need to suspend the exam before the Provider can access and complete the exam.



Message from webpage X

 Information saved, please inform examiner you have completed this information.

OK

Fields marked with an astensk (*) are required.
Numerical Readings must be recorded.

Urine Specimen

* Sp. Gr. * Protein * Blood

Place Exam on Hold pending further testing. Uncheck when lab

Urinalysis is required. Protein, blood or sugar in the urine may be an indication for further testing to rule out any underlying medical problem.

Other Testing describe and record

Close **Suspend** Submit

Suspend Test

Please enter any remarks you would like displayed for future reference.

Ready for Examiner

Cancel **Continue**

Suspending the Test – Open Events

All suspended test events will be moved to the 'Open Events' page.

- Home
- Pending List
- Open Events (2)**
- Search

Open Events

Filter By

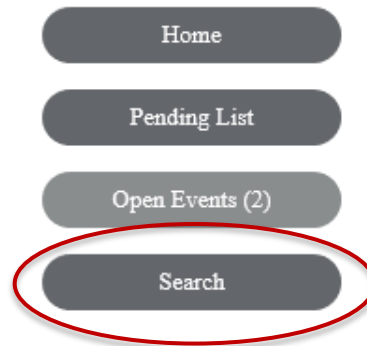
Search where Equal to [Pending Determination Exams](#)

Tests highlighted in red need your attention and should be taken care of as soon as possible.

Type	Donor Name	Donor ID	Scheduled Date/Time	Account #	Account Name	DotTest	Status	Collector	Suspended Date/Time	Elapsed Time	
PHY	White_Snow	*****9999	02/20/2018 01:50 PM			Yes	In Process	Jensik, Pamela			Delete
PHY	White_Snow	*****9999	03/27/2018 02:03 PM			Yes	Suspended	Jensik, Pamela	03/27/2018 02:50 PM	00:00	Delete

Revisiting Completed Exams

If you would like to revisit a completed exam that was completed within seven days, you can access the exam by selecting the 'Search' button.



You can re-print the Medical Examination Report and/or the Medical Examiner's Certificate at this time by clicking on either of the buttons found at the bottom of the screen.

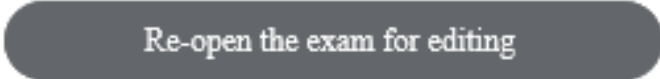


Editing a Completed Exam

Only Providers can edit the certification portion of the exam. Please get in touch with the provider that performed the exam if this tab requires editing.

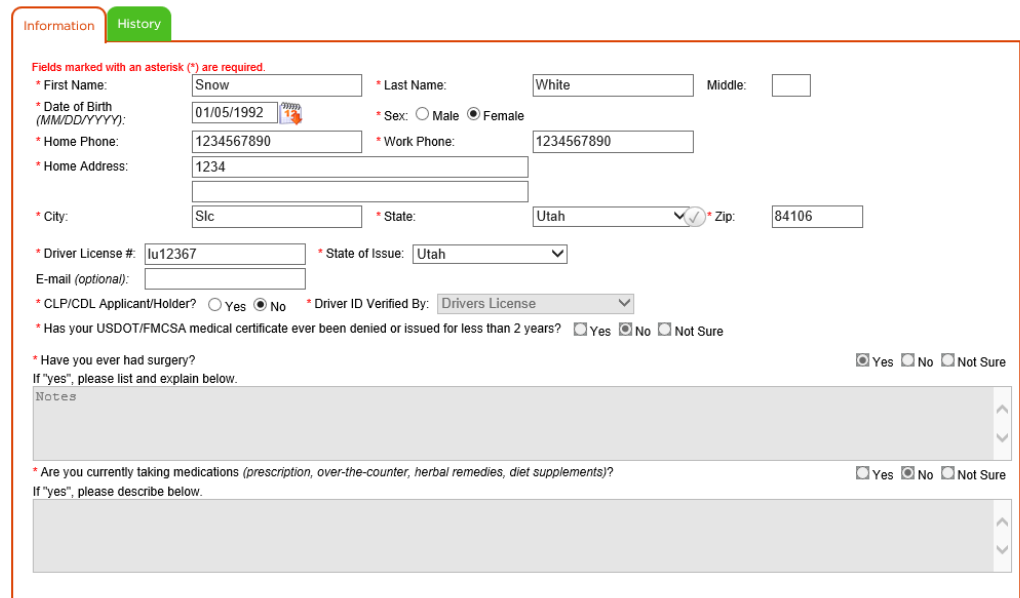
FormFox Users with Site Administrator access will be able to make edits to the 'Information Page.' If you do not see the 'Re-open the exam for editing' button, please contact the provider associated with the exam or a FormFox user with Administrator access.

Click the 'Re-open the exam for editing' button.



These Editable Fields Include:

- First Name
- Last Name
- Middle Name
- Date of Birth
- Gender
- Home Phone
- Work Phone
- Home Address
- City, State, and Zip
- Driver License #
- State of Issue
- CLP/CDL Applicant/Holder



Information History

Fields marked with an asterisk (*) are required.

* First Name: Snow * Last Name: White Middle:

* Date of Birth (MM/DD/YYYY): 01/05/1992 * Sex: Male Female

* Home Phone: 1234567890 * Work Phone: 1234567890

* Home Address: 1234

* City: Slc * State: Utah * Zip: 84106

* Driver License #: lu12367 * State of Issue: Utah

E-mail (optional):

* CLP/CDL Applicant/Holder? Yes No * Driver ID Verified By: Drivers License

* Has your USDOT/FCMSA medical certificate ever been denied or issued for less than 2 years? Yes No Not Sure

* Have you ever had surgery? Yes No Not Sure
If "yes", please list and explain below.

Notes

* Are you currently taking medications (prescription, over-the-counter, herbal remedies, diet supplements)? Yes No Not Sure
If "yes", please describe below.