

REPORT OF VISION EXAMINATION

SECTION 1 — APPLICANT COMPLETES THIS SECTION

INSTRUCTIONS: Please complete the driver license number, date of birth, telephone number, name, and address areas of this form. **You must sign and date the authorization line.** All medical information received by the Department of Motor Vehicles (DMV) is confidential under *California Vehicle Code (CVC) §1808.5*. Please bring this completed form and any new corrective lenses with you when you return to DMV for further testing. If any section of this form is incomplete, it may have to be returned to the vision specialist for completion. **DO NOT MAIL THIS FORM BACK TO DMV** unless asked to do so by a DMV employee. **Alterations or erased information may void this form.**

Your vision specialist should conduct a new vision examination unless one has been conducted within the last six months. **DMV will make the final licensing decision based on a combination of factors, including information from your vision specialist.**

DRIVER LICENSE NUMBER	DATE OF BIRTH (MO., DAY, YR.)	HOME TELEPHONE NUMBER ()
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NAME (FIRST, MIDDLE, LAST) _____

RESIDENCE ADDRESS	CITY	STATE	ZIP CODE
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I authorize the vision specialist conducting this examination to provide the Department of Motor Vehicles with the following information for its confidential use (CVC §1808.5) in evaluating my ability to safely operate a motor vehicle.

APPLICANT'S SIGNATURE	DATE
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- DMV's Visual Acuity Screening Standard is
- 20/40 with both eyes tested together, **and**
 - 20/40 in one eye, **and**
 - 20/70, at least, in the other eye.

SECTION 2 — OPHTHALMOLOGIST OR OPTOMETRIST COMPLETES THOSE SECTIONS THAT APPLY — Information must be from exam within last 6 months.

1. REFRACTION — Complete only those sections that apply.

HAVE NEW DISTANCE LENSES BEEN PRESCRIBED AND FITTED? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: <input type="checkbox"/> Glasses <input type="checkbox"/> Contact Lenses	DATE NEW LENSES WERE PRESCRIBED	IS NIGHT DRIVING RECOMMENDED? <input type="checkbox"/> Yes <input type="checkbox"/> No
IS MONOVISION EMPLOYED? By contact lenses <input type="checkbox"/> Yes <input type="checkbox"/> No By refractive surgery <input type="checkbox"/> Yes <input type="checkbox"/> No Is best corrected visual acuity in each eye recommended for driving? <input type="checkbox"/> Yes <input type="checkbox"/> No	DID YOUR PATIENT RECEIVE BIOPTIC LENS TRAINING? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known	DID PATIENT RECEIVE BIOPTIC LENS TRAINING THAT INCLUDED DRIVING? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known
Bioptic Telescope <input type="checkbox"/> Right eye 20/____ <input type="checkbox"/> Left eye 20/____ Bioptic Telescope suitable for driving? <input type="checkbox"/> Yes <input type="checkbox"/> No	SKILL IN USING BIOPTIC TELESCOPE <input type="checkbox"/> Satisfactory <input type="checkbox"/> Unsatisfactory <input type="checkbox"/> Not Known	

2. VISUAL ACUITY — Complete Clinical Measurement Section. Lenses include contact lenses or glasses.

	DMV MEASUREMENT (FOR DMV USE ONLY)			CLINICAL MEASUREMENT (WITHOUT BIOPTIC TELESCOPE)		
	Both Eyes	Right Eye	Left Eye	Both Eyes	Right Eye	Left Eye
Without Lenses	20/	20/	20/	Without Lenses	20/	20/
With Current Lenses	20/	20/	20/	With Lenses	20/	20/
	Best Corrected Visual Acuity			20/	20/	20/

3. DIAGNOSIS — Please indicate vision condition by checking the box(es) representing affected eye(s). If the diagnosed condition is not listed, write the diagnosis under "other diagnosis/comments" below.

REFRACTIVE	R	L	DEVELOPMENTAL	R	L	OPTICAL	R	L	RETINAL/OPTIC NERVE	R	L	VISUAL FIELDS	R	L
Astigmatism	<input type="checkbox"/>	<input type="checkbox"/>	Amblyopia	<input type="checkbox"/>	<input type="checkbox"/>	Cataract	<input type="checkbox"/>	<input type="checkbox"/>	Diabetic Retinopathy	<input type="checkbox"/>	<input type="checkbox"/>	Decreased Peripheral Vision	<input type="checkbox"/>	<input type="checkbox"/>
Hyperopia	<input type="checkbox"/>	<input type="checkbox"/>	Strabismus	<input type="checkbox"/>	<input type="checkbox"/>	Corneal Opacity	<input type="checkbox"/>	<input type="checkbox"/>	Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	Hemianopia	<input type="checkbox"/>	<input type="checkbox"/>
Myopia	<input type="checkbox"/>	<input type="checkbox"/>	Congenital Nystagmus	<input type="checkbox"/>	<input type="checkbox"/>	Diplopia (uncorrectable)	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Quadrantanopia	<input type="checkbox"/>	<input type="checkbox"/>
			Albinism	<input type="checkbox"/>	<input type="checkbox"/>	Keratoconus	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	Decreased Peripheral Vision. Please identify the areas affected on the chart in Section 5 (see reverse)		
						Aphakia	<input type="checkbox"/>	<input type="checkbox"/>	Retinitis Pigmentosa	<input type="checkbox"/>	<input type="checkbox"/>			
						Pseudophakia	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Damage	<input type="checkbox"/>	<input type="checkbox"/>			
						Post. Caps. Opac.	<input type="checkbox"/>	<input type="checkbox"/>	(CRVO, PRP etc.)					

Other diagnosis/comments _____

Monocular Vision (No Light Perception or Prosthesis) If monocular, when was the monocular vision diagnosed? _____

If monocular, does the patient have a medical condition that could affect the functional eye in the future? Yes No

Any eye surgery (including refractive)? Yes No Date of most recent surgery _____ Type of surgery _____



