



VISUAL SCREENING REPORT

APPLICANT INSTRUCTIONS

You are being asked to have your eyes examined by an ophthalmologist or optometrist to determine whether your sight may be improved by lens(es) or medical treatment.

If you have any questions about how well you must be able to see to be granted the privilege to drive in Oklahoma, the Hearing Officer or the Driver License Examiner will be able to assist you.

After this form has been completed by an ophthalmologist or optometrist based on an examination performed within the past sixty (60) days, it should be returned to the Department at the following address:

Department Of Public Safety, Attn: Medical Division, PO Box 11415 Oklahoma City OK 73136

The applicant is responsible for all fees incurred for the examination.

(Please type or print in ink)

STATE OF OKLAHOMA
DEPARTMENT OF PUBLIC SAFETY

MEDICAL DIVISION

Full Name of Person Examined _____
Last First Middle

Mailing Address _____
Street or PO Box City Zip

Driver License No. (if known) _____ Date of Birth _____

Date of Examination _____ Print Name of Specialist _____

Mailing Address Signature of Specialist

City, State and Zip Code Specialty

(_____) _____
Telephone number License # and State of

I hereby authorize the above named specialist to perform the examination and provide this information to the Department of Public Safety for driver license purposes.

Signature of patient

(See reverse side)

Attn Physician:

All applicants for original or renewal driver licenses and licensed drivers whose traffic records cause doubt as to their ability to drive safely, may have their vision screened by a Driver License Examiner. When more accurate measurements are needed, the licensee is asked to have an examination performed by an ophthalmologist or optometrist. A report from such a specialist is particularly valuable if the fitness of a person to drive is questionable.

Please sign this visual screening report to indicate your medical license number. Also for proper identification, please ask the person examined to sign the report in your presence. Visual screening reports from licensed practitioners will be acceptable. The specialist assumes no responsibility in making this report other than that of truthfully representing the facts.

THIS FORM MUST BE COMPLETED BY A LICENSED OPHTHALMOLOGIST OR OPTOMETRIST

| ACUITY | Right eye | Left eye | Both Eyes |
|-----------------------------|------------|------------|------------|
| <u>WITHOUT LENSES</u> | <u>20/</u> | <u>20/</u> | <u>20/</u> |
| <u>WITH PRESENT LENSES</u> | <u>20/</u> | <u>20/</u> | <u>20/</u> |
| <u>WITH BEST CORRECTION</u> | <u>20/</u> | <u>20/</u> | <u>20/</u> |

| | | | |
|------------------------------|-------------|--------------------------|-------------|
| FIELD OF VISION (in degrees) | | | |
| Right Eye: Temporal _____ | Nasal _____ | Left Eye: Temporal _____ | Nasal _____ |

(Please type or print legibly in ink - all sections must be completed)

Muscle balance _____ Is diplopia present? YES () NO ()

Do new lenses need to be fitted? YES () NO () If yes, have they been fitted? YES () NO ()

Describe any visual irregularities such as poor near vision, poor night vision, head tilt, etc.

Does this patient have an eye disease or eye injury? YES () NO () Is it progressive? YES () NO ()

If disease or injury is present, what is the diagnosis? _____

What steps are being taken, if any, to correct the condition _____

How often would you recommend re-examination for driving purposes? _____

Is this individual able to recognize the colors of traffic signals showing red and green? YES () NO ()

Would you recommend any restrictions be placed on this persons drivers license based on this examination (such as locale, max speed, daylight only, etc)? YES () NO () If yes, please explain specifically:

In your medical judgement, is the condition of the patient controlled? YES () NO () If no, explain:

Are you aware of any other significant medical condition(s) present? YES () NO () If yes, what is the condition(s)? _____