

Confidential Eye Examination Report

Driver/Patient Section			
Patient Last Name	First Name		Middle Initial
Street Address	City	State	ZIP
Customer Identification Number (CIN)	Date of Birth		
Driver Statement of Understanding (Driver signature not required for DMV processing): <ul style="list-style-type: none"> My Physician/Ophthalmologist/Optomterist will conduct an eye examination to determine my fitness to operate a motor vehicle safely and responsibly. My Ophthalmologist/Optomterist will respond to any additional questions from the Department of Motor Vehicles (DMV). I understand that this form will be considered in any decision regarding the issuance of my driver license, pursuant to C.R.S. 42-2-111 & 42-2-112. 			
Signature of Driver or Patient		Date (MM/DD/YY)	
Ophthalmologist/Optomterist/Physician Section			
Instructions: use your best clinical judgment as you REVIEW AND COMPLETE ALL SECTIONS. Base severity ratings within each category on your overall assessment of impairment relative to the driving task. Form must be completed by the Physician (MD or DO) or OD. Pursuant to C.R.S. 42-2-112, no civil or criminal actions shall be brought against any physician, physician's assistant, or optometrist licensed in Colorado for providing a medical opinion if the physician, physician's assistant, or optometrist acts in good faith and without malice.			
Colorado Vision Recommendations – 20/40 or better in either eye with or without corrective lenses, <i>and</i> total combined horizontal field of vision, with both eyes, of at least 120 degrees, or if blind in one eye, at least 60 degrees in the other eye. If best visual acuity with or without corrective lenses is worse than 20/100 in the carrier lenses, the bioptic telescope must correct the visual acuity to at least 20/40.			
Examination Information (check all that apply and please do not abbreviate) Applicant is currently being treated for one or more of the following progressive ocular condition(s): <input type="checkbox"/> Macular Degeneration <input type="checkbox"/> Retinitis Pigmentosa <input type="checkbox"/> Glaucoma <input type="checkbox"/> Visual Field Deficit <input type="checkbox"/> Other _____ <input type="checkbox"/> N/A			
Does patient have visual field deficit which makes driving unsafe? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Additional Information	Distance Acuity	Right	Left
	With Correction	20 /	20 /
	Without Correction	20 /	20 /
	Bioptic Lens	20 /	20 /
Horizontal Perception Fields			
Left: <input type="checkbox"/> Pass <input type="checkbox"/> Deficient <input type="checkbox"/> Fail	Right: <input type="checkbox"/> Pass <input type="checkbox"/> Deficient <input type="checkbox"/> Fail		

Require DMV retesting in one year? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Examination Date (MM/DD/YYYY)		Form is valid for 180 days from date of exam	
Patient Last Name		First Name	Middle Initial
Based on my observations of this patient and information relayed to me by this individual, I, reasonably and in good faith, believe that _____ is:			
Patient Name			
Recommended license restriction(s): <input type="checkbox"/> Daylight Driving Only <input type="checkbox"/> No Highway/Freeway Driving <input type="checkbox"/> Mile Radius Only _____ <input type="checkbox"/> Restricted MPH _____ <input type="checkbox"/> Biotopic Lens <input type="checkbox"/> Automatic Transmission Only <input type="checkbox"/> Other _____		}	Must Choose One <input type="checkbox"/> Fit to operate a motor vehicle safely. <input type="checkbox"/> Fit to operate a motor vehicle safely contingent upon passing a DMV Road Test. <input type="checkbox"/> NOT FIT to operate a motor vehicle safely and responsibly due to significant medical-functional compromise or deficit. <input type="checkbox"/> Fitness to drive determination pending; rehab permit required <input type="checkbox"/> Patient also requires a Medical Exam
Specialty (Required)			License Number (Required)
Street Address		City	State ZIP
Physician Name (Printed)		Signature (Required)	