North Carolina Department of Motor Vehicles Vision Specialist
Form DL77

I,_____, hereby authorize Dr._____to provide my examination information for the purposes of determining my visual fitness to operate a motor vehicle. I understand this authorizes the Division to review my case.

Applicant Signature_____License/Customer number_____

Parent/Guardian if Minor_____Telephone number_____

To be completed by licensed Ophthalmologist or Optometrist

1. What is the vision diagnosis?_____

2. Which eye(s) are affected: ☐ both ☐ right ☐ left

3. Is the condition: ☐ permanent ☐ stable ☐ progressive ☐ improving
(check all that apply)

4. Best corrected Visual Acuity:
(Using conventional lenses)

5. Uncorrected Visual Acuity:

Both 20/	Right 20/	Left 20/
Both 20/	Right 20/	Left 20/

6. New lenses prescribed? ☐ Yes ☐ No

7. Are corrective lenses recommended for driving? ☐ Yes ☐ No

8. What is the horizontal field of view in each eye without field expanders? (**Specify in degrees**)

Right Eye: _____° nasal _____° temporal	Left Eye: _____° nasal _____° temporal

Test used: ☐ Confrontation ☐ Goldmann ☐ Automated

9. Are there other visual issues that might affect driving?
☐ No ☐ Depth perception ☐Diplopia ☐Contrast sensitivity ☐Glare sensitivity ☐Color vision impairment

10. Is a bioptic telescope used for driving? ☐ Yes ☐ No **(If no, skip to # 16)**

11. If yes, how long has the bioptic been used? ☐ New Duration:_____months/years (circle)

12. If yes, for which eyes(s)? ☐ Both ☐ Right ☐ Left

13. Visual acuity through bioptic telescope: Both: 20/_____ Right: 20/_____ Left: 20/_____

14. Has the individual driven previously <u>without</u> a bioptic telescope? ☐Yes ☐No

15. Has the individual completed certified training in the use of a bioptic for driving? ☐Yes ☐No

16. Are there any other concerns regarding this individual's fitness to safely operate a motor vehicle?
☐No ☐ Cognitive ☐ Physical ☐ Psychological ☐ Other: _____

17. What driving restriction(s), if any, do you recommend based upon your examination?
☐None ☐45mph limit/No interstate ☐Daylight only ☐Local driving only: ☐miles from home ☐**Should not drive**

18. Do you feel the patient is medically fit to drive a car? Yes ___ No ___ If no please address on question #20.

19. Do you feel the patient is medically fit to drive a CMV/SCHOOL BUS? Yes ___ No ___

20. Has the driver been involved in a recent motor vehicle accident because of their medical conditions? Yes ___ No ___
Give your overall assessment of this patient's medical condition and any potential effect on safe driving. Please comment on all medical conditions, and any over-the-counter or prescription medications that might exacerbate the risk of driving.

_____

_____

21. Other recommendations for highway safety purposes (check all that apply):
☐ **DMV** follow-up recommend ☐ 6 months ☐every: circle: (1) (2) (3) year(s)
☐ DMV road test recommended by an examiner
☐ Other:_____

<u>Vision Examiner:</u>

Name_____Degree_____License #_____Address_____

Phone_____Fax_____

Signature_____Date_____

Instructions: Fax this completed and signed form to the NC DMV Medical Review Section at (919) 733-9569
Division of Motor Vehicles, Medical Review Unit, 3112 Mail Service Center, Raleigh NC 27697-3112