

**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)

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

5. Uncorrected Visual Acuity:

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
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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 without 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/No interstate _____ miles from home Daylight only **Should not drive**

18. 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.

19. 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: _____

Vision Examiner:

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