NORTH CAROLINA DIVISION OF MOTOR VEHICLES

VISION SPECIALIST FORM

I, the undersigned, hereby authorize my doctor to provide my examination information to the Division of Motor Vehicles for the purposes of reviewing my case to determine my visual fitness to operate a motor vehicle.

Applicant Name (Print)	
Driver License/Customer Number	
Parent/Guardian (if minor)	
Telephone Number	
Signature of Applicant	

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 (check all that apply): ☐ permanent ☐ stable ☐ progressive ☐ improving
4. Best corrected Visual Acuity (using conventional lenses): Both 20/_____ Right 20/_____ Left 20/_____
5. Uncorrected Visual Acuity: 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? ☐ Yes ☐ No (if yes, check all that apply)
   ☐ 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. How long has the bioptic been used? ☐ New ☐ Duration _____(specify years/months)
12. For which eye(s)? ☐ Both ☐ Right ☐ Left
13. Visual acuity through bioptic telescope: Both 20/_____ Right 20/_____ Left 20/_____
14. Has the individual previously driven 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 due to their condition? ☐ 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 medications (OTC or Rx) that may exacerbate the risk of driving.
    _____
    _____
19. Other recommendations for highway safety purposes (check all that apply)
    ☐ DMV follow-up recommended every ☐ 6 months ☐ 1 year ☐ 2 years ☐ 3 years
    ☐ DMV road test recommended ☐ Other: _____

Vision Examiner Name/Degree/License	
Address	
Telephone/Fax Number	
Signature of Vision Examiner	
Date	

Instructions: Fax this completed and signed form to the NCDMV Medical Review Unit at (919) 733-9569.