TIM TIPTON
COMMISSIONER

J. KEVIN STITT
GOVERNOR

STATE OF OKLAHOMA
DEPARTMENT OF PUBLIC
SAFETY

# VISUAL SCREENING REPORT

## APPLICANT INSTRUCTIONS

You have been referred to the Medical Standards Section of the Department of Public Safety because you do not meet the medical standards for vision pursuant to OAC 670:15-11-7. To obtain or retain your Oklahoma driver's license, you must have a vision examination conducted by an ophthalmologist or optometrist. This examination must establish medical treatment or corrective lenses that allow you to meet the vision standards for an Oklahoma driver's license.

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 Standards Unit, PO Box 53004 Oklahoma City OK 73152-9998.
You may also fax the completed form to 405-497-7035 or email it to medicaldesk@dps.ok.gov.

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

Patient/Licensee/Applicant Full Legal Name _____
*Last Name* *First Name* *Middle Name*

Date of Birth ____/____/____ Driver License Number
_____

Mailing Address _____
*Street* *City* *ST* *Zip*

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

_____
Signature of patient

## OPTOMITRIST/OPHTHALMOLOGIST INSTRUCTIONS

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 Service Oklahoma Driver License Examiner. When more accurate measurements are needed, 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.

Name of Specialist_____

Mailing Address_____

City_____ST_____ Zip_____

Specialty _____

License # and State of Licensure_____

Telephone Number _____

**THIS FORM MUST BE COMPLETED BY A LICENSED OPHTHALMOLOGIST OR OPTOMETRIST**

Patient Name: _____

| **ACUITY** | **Right Eye** | **Left Eye** | **Both Eyes** |
|---|---|---|---|
| Without Lenses | 20/ | 20/ | 20/ |
| With Present Lenses | 20/ | 20/ | 20/ |
| With Best Correction | 20/ | 20/ | 20/ |
| **FIELD OF VISION** (In degrees) | | | |
| Right Eye | Temporal | Nasal | |
| Left Eye | Temporal | Nasal | |

Muscle balance_____

Is diplopia present? Yes _____ No _____

Are new lenses required? 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, please provide the diagnosis? _____

_____

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

_____

How often do 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 person's driver license base on this examination (such as locale, max speed, daylight only, etc.)? Yes _____ No _____

*If yes, please explain* _____

_____

Is it your professional judgment the condition of the patient controlled? Yes _____ No _____

*If not, explain* _____

Are you aware of any other significant medical condition(s) present? Yes _____ No _____

*If yes, what is the condition(s)?* _____

Date of Examination: _____ Specialist Signature: _____