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 failed the vision screening during the driver license application process. To continue with the driver licensing process, you must have your eyes examined by an ophthalmologist or optometrist to determine whether your sight may be improved by lens(es) or medical treatment.

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 Section, PO Box 53004 Oklahoma City OK 73152-9998. You may also fax the completed form to 405-497-7035.

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

PHYSICIAN 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 Driver License Examiner. When more accurate measurements are needed, the licensee is asked to have an examination performed by an ophthalmologist or optometrist. 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, what is the diagnosis? _____

_____

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

_____

How often would 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? _____

_____

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: _____