

PLEASE RETURN COMPLETED
VISION FORM TO:

STATE OF KANSAS DIRECTOR OF VEHICLES
MEDICAL/VISION UNIT
300 SW 29th ST.
PO BOX 2188
TOPEKA KS 66601-2188

PH: (785) 368-8971
FAX: (785) 296-5857

KANSAS DIVISION OF VEHICLES VISION FORM

GENERAL INFORMATION & HISTORY – TO BE FILLED OUT BY THE PATIENT

Name: _____ Driver's License #: _____ DOB: _____
Address: _____ CITY/STATE/ZIP: _____
Phone Number: _____
Currently enrolled in Driver's Education? YES / NO If yes, instructor name & phone number: _____

RELEASE OF INFORMATION

Permission is granted for release of all vision information concerning me to the Kansas Division of Vehicles by all medical professionals filling out this form.

SIGNATURE OF PATIENT

DATE

To the Vision Professionals: You assume no responsibility in making this report other than that of truthfully representing the facts as they appear in your professional judgment. **The information on this form must be from an examination within the last 90 days. If you have any questions please call (785)368-8971.**

Instructions:

1. Please answer each question and fill out the entire form carefully and legibly.
2. Indicate yes or no whether from a visual standpoint only, this patient is capable of safely operating a motor vehicle.
3. Specify any driving restrictions that are appropriate based on the patient's vision condition.

SECTION I: VISION REPORT

	<u>Acuity Right Eye</u>	<u>Acuity Left Eye</u>	<u>Horizontal Field of Vision</u>
Visual Acuity without Glasses	20/____	20/____	Equal to or greater than 20°? Yes <input type="checkbox"/> No <input type="checkbox"/>
Visual Acuity with Glasses	20/____	20/____	
Best Correction	20/____	20/____	
Biopic/Telescopic (for vision specialist use only)	20/____	20/____	

Driver requires a Permit to test adaptive equipment.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does this patient require a drive test?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
This patient is capable of safely operating a motor vehicle. (Driver must be considered a safe candidate in order to request a drive test.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
An annual vision report should be required.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does this patient require a medical exam?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Indicate below which restrictions may apply to the patient's license if issued or continued: Maximum 6 restrictions. To remove a restriction(s) previously requested by a physician, please check the restriction box and write "R" beside it.

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Corrective Lenses | <input type="checkbox"/> Daylight Hours Only | <input type="checkbox"/> No Interstate Driving | <input type="checkbox"/> Outside Business Area |
| <input type="checkbox"/> Within City Limits | <input type="checkbox"/> Licensed Driver in Front Seat | <input type="checkbox"/> Automatic Transmission | <input type="checkbox"/> Outside Mirror |
| <input type="checkbox"/> Mechanical Aid | <input type="checkbox"/> Prosthetic Aid | <input type="checkbox"/> _____ Miles From Home (5-30 in 5 mile increments) | |

Name of Optometrist/Ophthalmologist (Please print)

Date of Examination

Address

Signature of Optometrist/Ophthalmologist

Phone

Date Signed