

LOUISIANA DEPARTMENT OF PUBLIC SAFETY & CORRECTIONS

OFFICE OF MOTOR VEHICLES

P. O. BOX 64886 • BATON ROUGE, LA 70896-4886

MEDICAL/VISION EXAMINATION FORM

DPSMV2015 (R0718)

The bearer of this medical examination form is being required to undergo an examination by a physician. Authority for the requirement is based on laws of the State of Louisiana relating to the issuance of drivers' licenses. The completed report of examination will be used by the Department of Public Safety and Corrections as a guide in making a final determination on the bearer's application, which is now pending.

NOTE TO APPLICANT: This medical examination form must be completed by your physician and returned to this office within 30 days from the "DATE ISSUED" indicated below. Failure to comply will result in the suspension of your driving privileges.

1. TO BE COMPLETED BY THE OFFICE OF MOTOR VEHICLES

Form section for Office of Motor Vehicles completion, including fields for Applicant's Name, DOB, R/S, D/L#, Address, City, Date Issued, MVCA's Initials, Badge#, Office#, Remarks, and Vision Results (Without and With Corrective Lenses).

APPLICANT FAILED TO COMPLY WITHIN 30 DAYS.

NOTE TO PHYSICIAN: In accordance with the provisions of R. S. 40:1356, a health care provider is exempt from any liability as a result of reporting to the Department of Public Safety and Corrections any visual ability, physical condition, impairment or disability which may impair a person's ability to exercise ordinary and reasonable control in the operation of a motor vehicle.

2. TO BE COMPLETED BY THE PHYSICIAN

Form section for Physician completion, divided into History and Orthopaedic sections with numbered questions regarding patient's medical history, vision, and physical condition.

HEARING	1. Does the patient have any hearing impairment? _____ If yes, is the patient considered to be deaf or hard of hearing? _____ 2. Is a hearing aid worn? _____ If yes, does it give sufficient correction? _____
CARDIOPULMONARY	1. Does patient have angina? _____ If yes, when does it occur? _____ strenuous activity _____ normal activity _____ at rest _____ 2. Does patient have dyspnea? _____ If yes, when does it occur? _____ strenuous activity _____ normal activity _____ at rest _____ 3. Does patient have syncope? _____ if yes, what is the frequency? _____ duration _____ last occurrence _____ 4. Does patient have dizziness? _____ describe _____ 5. What is patient's blood pressure? 1 st reading _____ 2 nd reading _____ 6. What is patient's pulse? Rate _____ Rhythm _____ 7. Has patient had cardiovascular catheterization or surgery? _____ If yes, describe _____ List medications and dosage: _____
NEUROLOGICAL	1. Does patient have epilepsy? _____ If yes, what type of seizures? _____ Date of last seizure? _____ Are seizures completely controlled? _____ Is patient under regular medical care? _____ What are the anticonvulsant serum blood levels? _____ 2. Does patient have any signs of Parkinsonism? _____ If yes, describe condition and severity _____ Is coordination normal? _____ If no, describe _____ 3. Does patient have any neurological disorder? _____ If yes, describe _____ List medications and dosage: _____ Is patient reliable in taking medication and following medical regimen? _____
MENTAL	1. Does patient have symptoms of any mental disorder? _____ If yes, describe condition and severity at present _____ 2. Has patient ever been treated in a mental hospital? _____ If yes, where and when _____ What was diagnosis and cure? _____ 3. Does patient use alcohol or drugs? _____ If yes, describe usage _____ 4. Is patient mentally deficient? _____ If yes, what was highest grade attained in school? _____ Age at attainment? _____ 5. Does patient have sufficient regard for his/her personal safety as well as that of others to operate a motor vehicle safely? Give details _____ 6. Is patient likely to act on sudden impulse without regard for the consequences of his/her behavior? _____ Give details _____ 7. On the basis of your examination and/or knowledge of this patient, do you recommend periodic psychiatric examinations? Give details _____ List medications and dosage: _____
DIABETES	1. Does patient have a history of diabetes? _____ If yes, is insulin taken? _____ is oral medication taken? _____ 2. What are patient's laboratory studies? recent urine sugars _____ recent blood sugars _____ 3. Has patient had any occurrences of diabetic coma? _____ If yes, give dates _____ 4. Has patient had any occurrences of insulin shock? _____ If yes, give dates _____ 5. Does patient have associated abnormalities? visual _____ renal _____ vascular _____ neurological _____ other _____ If yes, describe _____ 6. Does patient have hypoglycemia? _____ If yes, describe treatment _____ List medications taken and dosage: _____ 7. Is patient reliable in taking diabetes medication? _____ Is diabetes controlled? _____

3. TO BE COMPLETED BY OPTOMETRIST OR OPHTHALMOLOGIST

VISION	WITHOUT CORRECTIVE LENSES Right Eye 20/ ____ Left Eye 20/ ____ Both Eyes 20/ ____	WITH CORRECTIVE LENSES Right Eye 20/ ____ Left Eye 20/ ____ Both Eyes 20/ ____	WITH NEW Rx Right Eye 20/ ____ Left Eye 20/ ____ Both Eyes 20/ ____
	PERIPHERAL VISION FIELDS: Left _____ Right _____		
	ANGLE OF VISION: Temporal Nasal Temporal Nasal		
	1. Can applicant recognize and distinguish among traffic control signals and devices showing standard red, green and amber Colors? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	2. In your opinion, should the patient wear corrective lenses to operate a motor vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No		
3. Is there evidence of eye disease or injury that would affect the driving ability? _____ If so, describe _____			
4. In your opinion, should the patient be restricted to "Daylight driving only"? <input type="checkbox"/> Yes <input type="checkbox"/> No			
5. Do you recommend that an operator's license be denied on visual grounds? _____ If so, what grounds? _____			

4. TO BE SIGNED BY THE PATIENT

I hereby authorize the examining physician whose signature appears above to release all information and findings contained herein to the Louisiana Department of Public Safety and Corrections. The Louisiana Department of Public Safety and Corrections can release this information to such individuals or groups as may be considered necessary and appropriate to determine my ability to safely operate a motor vehicle.

Date _____ Signature of Patient _____

5. TO BE COMPLETED, SIGNED AND DATED BY THE PHYSICIAN (MEDICAL) OR OPTOMETRIST/OPHTHALMOLOGIST (VISION)

PLEASE REFER TO "NOTE TO PHYSICIAN:" on the first page of this form. Are you this patient's treating physician? _____

In your opinion, from a medical/vision standpoint, is it safe for this patient to operate a motor vehicle? _____

On the basis of your examination and/or knowledge of this patient, do you recommend periodic medical/vision reports be submitted? _____

If yes, how often? 6 months 1 year 2 years other _____ Remarks: _____

Physician's Signature _____ Date _____

Physician's Printed Name _____ Telephone# _____

Physician's Address _____