

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
WEBSITE: KSREVENUE.GOV

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 vision and vision/medical professionals filling out this form. Minors may sign/date their own form or their Guardian may sign/date the form if the Minor is under 18 years of age.

SIGNATURE OF PATIENT/GUARDIAN (if patient under 18 years of age)

DATE

SECTION I: VISION REPORT – TO BE FILLED OUT BY THE VISION PROFESSIONAL (K.S.A 8-295/K.A.R. 92-52-12)

The information on this form must be from an examination within the past 90 days (8-241(a)(1)).

	<u>Acuity Right Eye</u>	<u>Acuity Left Eye</u>	<u>Horizontal Field of Vision</u>
Visual Acuity Without Glasses/Contacts	20/_____	20/_____	Equal to or greater than 20°?
Visual Acuity With Glasses/Contacts	20/_____	20/_____	
Bioptic/Telescopic (for vision specialist use only)	20/_____	20/_____	
(The Bioptic/Telescopic readings are not used to determine issuance or drive test requirements)			Yes <input type="checkbox"/> No <input type="checkbox"/>

Vision Condition Diagnosis: _____

Vision Condition Prognosis: _____

An annual vision report is recommended due to vision condition.

Corrective eyewear (glasses/contacts) are recommended to be worn when driving.

Driver requires adaptive equipment to drive. Yes No

Does this patient require a drive test or driver education (if not licensed)? Yes No

As of the date of this vision exam, there is no reason to believe that the person's eyesight would preclude that person from operating a vehicle. Yes No

(The answer to this question must be "yes" in order to request an examiner drive test or driving rehabilitation assessment. A driving rehabilitation assessment may be requested by a doctor or as a result of a failed drive test.)

Do you recommend this patient have a medical exam? Yes 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 vision professional, 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) | |

If **Mechanical Aid** is required for driving, please advise what type: _____

If **Prosthetic Aid** is required for driving, please advise if right side, left side or both: _____

Provider Comments: _____

Name of Vision Professional (Please print)

Address

Phone

Date of Examination (within past 90 days or 6 months after a seizure occurred)

Signature of Vision Professional

Date Signed