

Initial Visual Examination for Kentucky Bioptic Driving Program

APPLICANT INFORMATION

| | | |
|----------|------------------------|----------------|
| Name: | | Date of Birth: |
| Address: | | Phone: |
| City: | State: Kentucky | Zip Code: |

I authorize this information to be released to the Kentucky Office of Vocational Rehabilitation, the State Police and Transportation Cabinet.

Signature of Applicant: _____ Date: _____

RESULTS OF EYE EXAMINATION

| | | |
|--|----------------------|---------------------|
| Date of Exam: | Performed by: | |
| Unaided Visual Acuity | OD (Right) 20/ _____ | OS (Left) 20/ _____ |
| Present Distance Refraction & Best Corrected Distance Visual Acuity | OD _____ 20/ ____ | OS _____ 20/ ____ |
| Size of Visual Field (Use V4e isopter or equivalent) *** Note*** Enclose Copies of Visual Fields | Instrument Used: | |
| Total Width (horizontal): | OD _____ degrees | OS _____ degrees |
| Total Width (vertical): | OD _____ degrees | OS _____ degrees |
| Diagnoses of Eye Condition: | | |
| OD | | |
| OS | | |
| Over the next 12 months (1 year), patient's present level of vision is expected to: (please circle one) | Remain Stable | Decline Improve |
| Does patient's visual condition cause true night blindness (nyctalopia)? (please circle one) | YES | NO |
| Does patient's visual condition have a dark adaptation time so slow or a glare resistance and recovery time so slow as to render it difficult for him to see well driving at night or at twilight times? (please circle one) | YES | NO |
| Should this person be restricted to driving only during daylight? (please circle one) | YES | NO |
| Color Perception adequate to recognize Traffic Signal Colors (red, green, amber)? (please circle one) | YES | NO |
| This patient is OK for Night Driving Evaluation, Training, and Testing: (please circle one) | YES | NO |

RESULTS OF EVALUATION WITH TELESCOPIC LENSES

| | | | |
|------------------------------|----------------------|---------------------|--------|
| Acuity with Telescope | OD (Right) 20/ _____ | OS (Left) 20/ _____ | |
| Power and Model of Telescope | OD _____ X | OS _____ X | Model: |

EXAMINER DATA (OPHTHALMOLOGIST OR OPTOMETRIST)

| | | | |
|------------|-------|------------------------|------|
| Name: | | Degree: | |
| Address: | | State: | Zip: |
| Signature: | Date: | Certification/License: | |