DR 2402 (09/03/20)
COLORADO DEPARTMENT OF REVENUE
Division of Motor Vehicles
P.O. Box 173350
Denver CO 80217-3350
FAX: (303) 205-8301

Confidential Eye Examination Report

Driver/Patient Section

Patient Last Name	First Name		Middle Initial
Street Address	City	State	ZIP
Customer Identification Number (CIN)	Date of Birth		

Driver Statement of Understanding (Driver signature not required for DMV processing):

- My Physician/Ophthalmologist/Optometrist will conduct an eye examination to determine my fitness to operate a motor vehicle safely and responsibly.
- My Ophthalmologist/Optometrist will respond to any additional questions from the Department of Motor Vehicles (DMV).
- I understand that this form will be considered in any decision regarding the issuance of my driver license, pursuant to C.R.S. 42-2-111 & 42-2-112.

Signature of Driver or Patient	Date (MM/DD/YY)

Ophthalmologist/Optometrist/Physician Section

Instructions: use your best clinical judgment as you REVIEW AND COMPLETE ALL SECTIONS. Base severity ratings within each category on your overall assessment of impairment relative to the driving task. Form must be completed by the Physician (MD or DO) or OD. Pursuant to C.R.S. 42-2-112, no civil or criminal actions shall be brought against any physician, physician's assistant, or optometrist based in Colorado for providing a medical opinion if the physician, physician's assistant, or optometrist acts in good faith and without malice.

Colorado Vision Recommendations – 20/40 or better in either eye with or without corrective lenses, *and* total combined horizontal field of vision, with both eyes, of at least 120 degrees, or if blind in one eye, at least 60 degrees in the other eye. If best visual acuity with or without corrective lenses is worse than 20/100 in the carrier lenses, the bioptic telescope must correct the visual acuity to at least 20/40.

Examination Information (check all that apply and please **do not** abbreviate)

Applicant is currently being treated for one or more of the following progressive ocular condition(s):

☐ Macular Degeneration ☐ Retinitis Pigmentosa ☐ Glaucoma
☐ Visual Field Deficit ☐ Other _____ ☐ N/A

Does patient have visual field deficit which makes driving unsafe? ☐ Yes ☐ No

Additional Information

Distance Acuity	Right	Left	Both
With Correction	20 /	20 /	20 /
Without Correction	20 /	20 /	20 /
Bioptic Lens	20 /	20 /	20 /

Horizontal Perception Fields

Left: ☐ Pass ☐ Deficient ☐ Fail	**Right:** ☐ Pass ☐ Deficient ☐ Fail

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Need DMV Re-Examination in one year? ☐ Yes ☐ No

Examination Date (mm/dd/yyyy)	**Form is valid for 180 days from date of exam**

Patient Last Name	First Name	Middle Initial

Based on my observations of this patient and information relayed to me by this individual, I, reasonably and in good faith, believe that

_____ is:
Patient Name

Recommended license restriction(s):

- ☐ Daylight Driving Only
- ☐ No Highway/Freeway Driving
- ☐ Mile Radius Only _____
- ☐ Restricted MPH _____
- ☐ Bioptic Lens
- ☐ Automatic Transmission Only
- ☐ Other_____

Must Choose One

- ☐ Fit to operate a motor vehicle safely.
- ☐ Fit to operate a motor vehicle safely contingent upon passing a DMV Road Test.
- ☐ **NOT FIT** to operate a motor vehicle safely and responsibly due to significant medical-functional compromise or deficit.
- ☐ Fitness to drive determination pending; rehab permit required

☐ Patient also requires a Medical Exam

Specialty (Required)	License Number (Required)	Phone Number (Required)	
Street Address	City	State	ZIP
Physician Name (Printed)	Signature (Required)		