DR 2401 (06/20/17)
COLORADO DEPARTMENT OF REVENUE
Division of Motor Vehicles
P.O. Box 173350
Denver, CO 80217-3350

Confidential Medical / Eye Examination Report

For confidential use of the DMV in making decisions on the individual's (Named Below) qualifications as a driver. This opinion shall only be divulged to the applicant or driver or in a trial or proceeding concerning the individual's qualifications to receive or retain a driver's license. (C.R.S. 42-2-111 and 42-2-112)

Date	Office	Office Number	Examiner

Applicant's First Name	Last Name	Middle Initial	Date of Birth

Address	City	State	ZIP

Current License Number *(Optional)*	State

Section 1: Authorization to Attending Physician/Optometrist

To (Physician/Optometrist)

Note: Physician please complete Sections II and III below. Optometrist please complete Sections IV and V on the reverse side.

I, ______________________________ hereby authorize the above named physician/optometrist to give the Colorado Department of Revenue, or its representative, any information he/she may have regarding my condition when under his/her observation or treatment.

Applicant's Signature	Date

Section 2: Physician's Report of Medical Examination

1. From your assessment of the medical history, physical examination and laboratory data, and in consideration of public safety, would authorization of a driving privilege be medically prudent as of today? ☐ Yes ☐ No

   Road test required ☐ Yes ☐ No ☐ Rehab Permit Only (If it is not prudent to authorize a driving privilege—NO road test will be given.)

   If road test required above, check one: ☐ Road Test Prior to any Driving Privileges or ☐ Road test Within 30 Days

2. What medical restrictions and/or prostheses are necessary for the above named applicant to operate a motor vehicle? (This approved medical report is contingent upon the following indicated restriction(s) appearing on applicant's instruction permit and/or driver's license. Failure to comply will result in the cancellation and denial of applicant's driving privilege.)

Remarks:

Physician's First Name	Last Name	Title	Phone Number ( )

Address	City	State	ZIP

Signature	Date of Evaluation (Must be within last 180 days)

Section 3: Report of Medical Examination

Physician The information requested herein will be used to evaluate the driving abilities of the applicant. The final determination of this risk, if any, depends on your prompt and accurate completion of this form. **Notes: As provided by law, licensed physicians and optometrists are immune from civil and criminal action if they act in good faith and without malice C.R.S. 42-2-112 The physician assumes no responsibility in making this report other than that of representing the facts as they appear from this professional examination. Your medical remarks will be held in confidence.**

Hearing (if impaired)	Right Ear	Left Ear	Vision			Blood Pressure
Whispered voice, standing sideways with distant ear closed.	Ft.	Ft.	Best corrected vision, both eyes open	20/		

Check each item in appropriate column (Enter NE, if not evaluated)	Normal	Abnormal	**Notes:** Describe every abnormality in detail. Enter applicable item numbers before each comment. Use additional sheet if necessary and attach to this form.
1.Head, Face, Neck			
2.Heart			
3.Lungs			
4.Extremities			
5.Musculo-Skeletal			
6.Endocrine			
Diabetes			
7.Neurologic			
8.Psychiatric			
Serious Neurosis			
Psychosis			
Serious Personality Deviation			
9.Other			

10.Does history indicate seizures or lapses of consciousness? ☐ Yes ☐ No *(If yes, complete the questions below)*

Date of Onset	Frequency	Dates of Last Two Seizures or Lapses

Describe any seizures/lapses of consciousness

Probable diagnosis

(Continued on next page)

Section 4: Eye Examination Report

1. From your assessment of the visual history, visual examination and laboratory data, and in consideration of public safety, would authorization of a driving privilege be medically prudent as of today? ☐ Yes ☐ No

   If it is not prudent to authorize a driving privilege, NO road test will be given. Road test Required? ☐ Yes ☐ No

   If road test required above, check one: ☐ Road Test Prior to any Driving Privileges or ☐ Road test Within 30 Days

Special Restrictions:

☐ Daylight Driving Only ☐ Area Radius ________ Miles from home ☐ Not more than ________ MPH

☐ Right Sideview Mirror ☐ Left Sideview Mirror ☐ Other ________________________________

Optometrist's First Name	Last Name	Title	Phone Number ( )

Address	City	State	ZIP

Signature	Date of Evaluation (Must be within last 180 days)

Section 5: Report on Examination of Eye Condition

Acuity (Check appropriate boxes)	Both		Right		Left	
Without Correction	20/		20/		20/	
With Glasses	20/		20/		20/	
With Contact Lenses	20/		20/		20/	
Bioptic Lenses	20/		20/		20/	
Carrier Lens	20/		20/		20/	

Coordination: Phorias (To be measured at 20 feet)

Horizontal:	Exo	Eso
Vertical:		

Fusion: ☐ Excellent ☐ Good ☐ Poor ☐ None

Depth Perception: ☐ Excellent ☐ Good ☐ Poor ☐ None __________

Fields-Horizontal Perception Fields:

Right		Left		☐ Pass ☐ Deficient ☐ Fail

Color:

☐ Traffic Lights ☐ Holmgren ☐ Ishihara ☐ Edrige ☐ Nagel ☐ Other:______________________________

Response to Light: (Please furnish if testing equipment is available)

Pupillary Reflex	Right		Left	
Glare Resistance	Right		Left	
Glare Recovery	Right		Left	

Injury or Disease *(Please describe fully)*

I understand that this form will be considered in any decision regarding the issuance of my driver's license.

Signature	Date