EYE CARE PROFESSIONAL'S MEDICAL REPORT
P-142OP REV. 5-2001

STATE OF CONNECTICUT
DEPARTMENT OF MOTOR VEHICLES
MEDICAL REVIEW DIVISION
On The Web At http:// dmvct.org

TO: Department of Motor Vehicles, Medical Review Division, 60 State Street, Wethersfield, CT 06161-2510

PATIENT'S NAME	DATE OF BIRTH	TELEPHONE NO.

ADDRESS

DATE OF EXAMINATION	VISUAL ACUITY (SC) *(Snellen)*	RE	LE	OU
		RE	LE	OU

Are corrective lenses required for driving? ☐ YES ☐ NO **Both eyes present (Y/N)?** **One eye present (Y/N)?**

Uninterrupted visual field in the horizontal direction, to the right of fixation. _____ ^{o} *(Degrees)*

Uninterrupted visual field in the horizontal direction, to the left of fixation. _____ ^{o} *(Degrees)*

Does the patient have any significant blind spots? ☐ YES ☐ NO **If yes, please specify below.**

Is patient color blind (Red, Green, Amber)? ☐ YES ☐ NO

Does patient have any other medical condition you are aware of, that may affect his/her ability to drive? ☐ YES ☐ NO **If yes, please specify below.**

Does the patient have a deteriorating condition? ☐ YES ☐ NO **If yes, please specify condition and indicate how often the patient should be re-examined?**

ADDITIONAL COMMENTS

NO TELESCOPIC LENSES PERMITTED

I certify that I have personally examined the above named person. In the interest of public safety I am submitting this report to the Department of Motor Vehicles and/or its Medical Advisory Board for their confidential use in making an assessment concerning the meeting of required standards to hold a Connecticut motor vehicle operator's license.

EYE CARE PROFESSIONAL'S NAME *(Please Print or Type)*	OFFICE ADDRESS *(Include Zip Code)*

EYE CARE PROFESSIONAL'S TYPE OF DEGREE

☐ **OPHTHALMOLOGIST** ☐ **OPTOMETRIST** ☐ **OTHER** *(Please Specify)*

TELEPHONE NUMBER	EYE CARE PROFESSIONAL'S LICENSE NUMBER	PHYSICIAN'S SPECIALTY *(If applicable)*

EYE CARE PROFESSIONAL'S SIGNATURE	DATE REPORT COMPLETED
X	