STATE OF CALIFORNIA DMV DEPARTMENT OF MOTOR VEHICLES
A Public Service Agency

REPORTE DE EXAMEN DE LA VISTA

962

(Formulario válido durante 6 meses a partir de la fecha del examen)

EL SOLICITANTE DEBE COMPLETAR ESTA SECCIÓN

NÚMERO DE LICENCIA DE MANEJAR	FECHA DE NACIMIENTO (MES, DÍA, AÑO)	NÚMERO TELEFÓNICO DEL DOMICILIO

NOMBRE (PRIMER NOMBRE, SEGUNDO NOMBRE, APELLIDO)

DOMICILIO RESIDENCIAL	CIUDAD	ESTADO	CÓDIGO POSTAL

FECHA DE LA SOLICITUD	OFICINA LOCAL

Autorizo al especialista de la vista que realiza este examen a proporcionar al DMV la información siguiente para su uso confidencial (Seccón 1808.5 del CVC), acerca de la evaluación de mi capacidad para manejar un vehículo motorizado sin ningún peligro.

FIRMA DEL SOLICITANTE	FECHA

EL OFTALMÓLOGO U OPTOMETRISTA COMPLETA ESTA SECCIÓN (Instrucciones al reverso)

1. REFRACTION

HAVE NEW DISTANCE LENSES BEEN PRESCRIBED AND FITTED?

☐ Yes ☐ No If yes: ☐ Glasses ☐ Contact Lenses ☐ One Bioptic Telescope ☐ Two Bioptic Telescopes

DATE NEW LENSES WERE PRESCRIBED

IF DISTANCE LENSES WERE PRESCRIBED AND FITTED, IS THIS THE BEST POSSIBLE CORRECTION? IF NO, EXPLAIN.

☐ Yes ☐ No

IF A BIOPTIC TELESCOPIC LENS WAS PRESCRIBED, IS IT

☐ Galilean ☐ Keplerian ☐ Periscope/Keplerian ☐ Other _____

DID YOUR PATIENT RECEIVE TRAINING IN USING THE BIOPTIC TELESCOPIC LENS?

☐ Yes ☐ No

IF YES, WAS DRIVING INCLUDED IN THE TRAINING?

☐ Yes ☐ No

2. VISUAL ACUITY

DMV MEASUREMENT	Both Eyes	Right Eye	Left Eye	CLINICAL MEASUREMENT WITHOUT BIOPTIC TELESCOPE	Both Eyes	Right Eye	Left Eye
Without Lenses	20/	20/	20/	Without Lenses	20/	20/	20/
With Lenses	20/	20/	20/	With Correction	20/	20/	20/

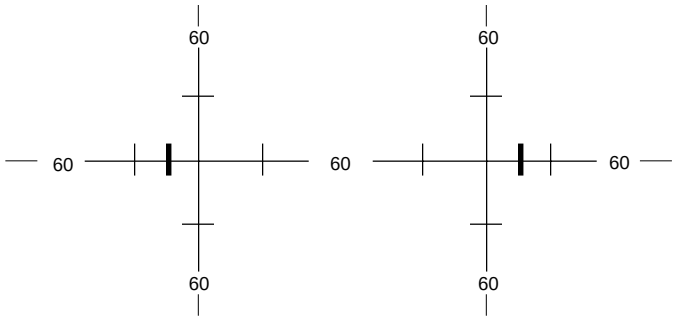
3. VISUAL FIELDS

A full visual field examination, using a standard test object such as a 10mm white mark, must be performed. Show the approximate peripheral extent and any **scotomas** in the diagram below.

LEFT EYE

Extent:
Left _____
Right _____
Up _____
Down _____

☐ Diagram is attached.



RIGHT EYE

Extent:
_____ Left
_____ Right
_____ Up
_____ Down

4. DIAGNOSIS

Please indicate the severity of the vision condition by placing a number 1, 2, or 3 in the box representing the affected eye(s) (1 = mild 2 = moderate 3 = severe). Definitions of mild, moderate, and severe, for each condition can be obtained from DMV. See "Understanding DMV's Vision Policies", form DL 62A, available from any DMV office. If your patient has Hemianopia or Pseudophakia, check the box representing the affected eye.

	R	L		R	L		R	L		R	L		R	L
Amblyopia	☐	☐	Diabetic Retinopathy	☐	☐	Hyperopia	☐	☐	Nystagmus	☐	☐	Retinal Detachment	☐	☐
Aphakia	☐	☐				Keratoconus	☐	☐	Pseudophakia	☐	☐			
Astigmatism	☐	☐	Diplopia	☐	☐	Macular Degeneration	☐	☐	Decreased Peripheral Vision	☐	☐	Retinitis Pigmentosa	☐	☐
Cataract	☐	☐	Glaucoma	☐	☐									
			Hemianopia*	☐	☐	Myopia	☐	☐				Strabismus	☐	☐

Monocular ☐ ☐ Could the condition in the blind eye affect the fellow eye in the future? ☐ Yes ☐ No

When was the monocular vision diagnosed? _____

Other ☐ ☐ _____

*Hemianopia: Please identify the quadrants affected on the chart above.

5. PROGNOSIS

☐ Stable ☐ Potentially progressive ☐ Improvement possible

PLEASE ESTIMATE HOW SOON YOUR PATIENT'S VISION SHOULD BE REEVALUATED.

☐ 6 mos. ☐ 1 year ☐ 2 years ☐ 4 years ☐ Other _____

6. ADVICE

What advice have you given your patient about driving?

☐ Drive in familiar areas only ☐ No night driving ☐ Do not drive ☐ No advice given ☐ Other _____

PRINTED NAME	SIGNATURE	M.D. OR O.D. LICENSE NUMBER	DATE OF EXAM
	X		

ADDRESS	CITY	ZIP CODE	TELEPHONE NUMBER
			( )

INSTRUCCIONES PARA LLENAR ESTE FORMULARIO

La información que aparece a continuación ayudará al solicitante y al oftalmólogo u optometrista a completar el anverso de formulario. La información exacta necesaria para determinar la capacidad visual para manejar del paciente/solicitante.

SECCIÓN DEL SOLICITANTE

Complete las áreas del número de licencia de manejar, fecha de nacimiento, número telefónico, nombre y dirección de este formulario. La fecha de solicitud es la fecha en que recibió este formulario del DMV. La oficina local es la oficina del DMV que le envió este formulario. Ingrese el nombre de la ciudad donde se encuentra la oficina. Debe firmar e indicar la fecha en la línea de autorización. Esto permite que el médico de los ojos proporcione al DMV la información acerca de su vista.Toda la información médica que recibe el DMV es confidencial según la sección 1808.5 del Código de Vehículos de California. Traiga con usted el formulario completo cuando regrese al DMV a someterse exámenes adicionales. NO DEVUELVA POR CORREO ESTE FORMULARIO AL DMV a menos que un empleado del DMV se lo pida. Este formulario se anulará si contiene información alterada o borrada.

Se espera que su especialista de la vista realice un examen completo de sus ojos. La información que aparece en los expedientes de su vista de más de 6 meses de antigüedad, no deben reportarse en este formulario.

OPHTHALMOLOGIST'S OR OPTOMETRIST'S (EYE DOCTOR) SECTION

The remainder of the form will be completed by an eye doctor. The form has been designed so most of the information can be provided quickly by checking the appropriate boxes. If you wish to provide additional information, please attach additional sheets.

1. **REFRACTION:** Please check "yes" or "no." If "yes," check the type of lenses you have prescribed for your patient and the date of the prescription. Record "yes" or "no" if new lenses are the best possible correction. If "no," please explain.
2. **VISUAL ACUITY:** Your patient's visual acuity has already been tested in one of DMV's field offices. An Optec 1000 device was used to measure visual acuity. These scores are recorded in the box "DMV Measurement."

   Please enter your patient's visual acuity reading in the box "Clinical Measurement." All appropriate spaces under this heading **MUST** be filled in by the eye doctor. Lenses include both contact lenses or glasses.
3. **VISUAL FIELDS:** Please perform a full visual field examination using a standard test object such as a 10mm white mark. Measure and record both nasal and temporal fields for each eye. Please show scotomas on the diagram.
4. **DIAGNOSIS:** Various vision conditions are listed with a box to indicate the severity of the condition. 1 represents a mild condition, 2 represents a moderate condition, and 3 represents a severe condition. Definitions of mild, moderate, and severe are explained in "Understanding DMV's Vision Policies" (DL 62A), available from any DMV office. Check the box which indicates your patient's vision condition. If the diagnosed condition is not listed, write the diagnosis under "other." Indicate if the left, right, or both eyes are affected by the vision condition by placing an "L," "R," or "B" on the line following the condition.
5. **PROGNOSIS:** Mark either "Stable," "Potentially Progressive," or "Improvement possible." Please note if your patient has multiple conditions and whether some are stable while others are progressive. For unstable conditions, please recommend when a reexamination by DMV is advisable.
6. **ADVICE:** Indicate if you have counseled your patient concerning visual field loss and any advice you may have given your patient regarding driving.

COMMENTS: Report any additional information or comments you feel DMV should know concerning your patient's visual and perceptual capabilities relating to driving performance. Use an additional sheet of paper to provide this information as well as information about any existing conditions which contribute to poor night vision or poor depth perception. Also note if you have given your patient advice regarding driving. Any recommendations about the patient's general safety should also be made. ***DMV will make the final licensing decision based on your professional expertise and other information DMV has on your patient.***

SIGNATURE: Your signature and address are necessary to validate this report. Please include your physician or optometrist license number.

Return the completed form to your patient. Your patient is responsible for returning this form to DMV.