



WYOMING DEPARTMENT OF TRANSPORTATION
 Driver Services
 5300 Bishop Blvd.
 Cheyenne, Wyoming 82009-3340
 Phone: 777-4855 Fax: 777-3823

DRIVER VISION EVALUATION

NAME (Print name as it appears on the driver license)			DRIVER LICENSE NUMBER
MAILING ADDRESS			DATE OF BIRTH
CITY	STATE	ZIP CODE	MVID NUMBER (Staff Use Only)

Dear Doctor: Please complete this form, in detail, and return it to the above address for evaluation.

	<u>WITHOUT LENSES</u>	<u>WITH PRESENT LENSES</u>	<u>WITH BEST POSSIBLE CORRECTION</u>
RIGHT EYE	20/_____	20/_____	20/_____
LEFT EYE	20/_____	20/_____	20/_____
BOTH EYES	20/_____	20/_____	20/_____

1. Date of last examination: _____

2. Is patient's **combined horizontal visual field** at least 120 degrees? YES NO
 Does patient have **depth perception**? YES NO

3. Is patient wearing **best possible correction**? YES NO
 Should patient wear prescribed **corrective lenses** when driving? YES NO

4. Does patient require special **low vision aids**? YES NO
 If yes, explain: _____

5. Visual condition(s) _____
 Is condition **progressive**? YES NO

6. Should patient be limited to **daylight driving only**? YES NO

7. From a vision standpoint, should any **additional restrictions** be imposed on driving? YES NO
 If yes, what restrictions do you recommend? _____

REMARKS/COMMENTS: _____

 EYE SPECIALIST'S NAME

 ADDRESS

 TELEPHONE #

 CLASSIFICATION OR SPECIALITY

 EYE SPECIALIST'S SIGNATURE

 DATE

