Shepherd Center

Vision Exam and Approval for Driving Evaluation

This form is only necessary if you have a visual field cut or loss of vision in a particular direction/side or if your distance vision is not 20/60 or better.

Patient Information

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Home Phone: _____ Cell Phone: _____ E-mail: _____

Regarding the request to resume safe, independent driving, this form must be completed by your ophthalmologist, optometrist, or low-vision specialist, addressing the following visual areas related to driving. Shepherd Center is unable to perform the on-the-road evaluation without first obtaining this signed form if a visual concern is present.

Date of Exam: _____

☐ Diagnosis: _____ ☐ Corrective lens: ☐ Near ☐ Distance ☐ Both

☐ Telescopic lens:

Type: _____ Power: _____

	Right	Left	Both	Comments
Corrected Visual Acuity				
Horizontal Visual Fields in Degrees				Assessment used:
Peripheral Vision				Assessment used:
Saccades				
Range Of Motion				

	Intact	Impaired	Comments
Color Vision			
Night Vision			
Depth Perception			
Diplopia	☐ Absent	☐ Present	

Do you recommend any driving restrictions? Please specify below:

_____

"Pursuant to Georgia Law (O.C.G.A.§ 40-5-27). A driver must meet the following vision requirements to be issued a license: • Acuity of 20/60 or better, corrected, or uncorrected in at least one eye • Visual Horizontal field of vision with both eyes open of at least 140 degrees • If only one eye has usable vision, the horizontal field of vision must be at least 70 degrees temporally and 50 degrees nasally."

Referral Source

Provider Name: _____ Phone: _____ Fax: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

I understand that by signing this form, the above-named person has met state requirements for vision in regard to driving and is visually appropriate to pursue a driving evaluation.

Provider Signature: _____ **Date:** _____

Have this form faxed to 404-367-1290.