LOUISIANA DEPARTMENT OF PUBLIC SAFETY & CORRECTIONS

OFFICE OF MOTOR VEHICLES

P. O. BOX 64886 • BATON ROUGE, LA 70896-4886

MEDICAL/VISION EXAMINATION FORM

DPSMV2015 (R0718)

The bearer of this medical examination form is being required to undergo an examination by a physician. Authority for the requirement is based on laws of the State of Louisiana relating to the issuance of drivers' licenses. The completed report of examination will be used by the Department of Public Safety and Corrections as a guide in making a final determination on the bearer's application, which is now pending.

NOTE TO APPLICANT: This medical examination form must be completed by your physician and returned to this office within 30 days from the "DATE ISSUED" indicated below. Failure to comply will result in the suspension of your driving privileges.

1. TO BE COMPLETED BY THE OFFICE OF MOTOR VEHICLES

APPLICANT'S NAME _____ DOB _____ R/S_____ D/L#_____

ADDRESS _____ CITY _____

DATE ISSUED _____ MVCA'S INITIALS _____ BADGE# _____ OFFICE# _____

REMARKS (must indicate which sections are required to be filled out by the physician and the reason the form is being issued):

_____

_____

OFFICE OF MOTOR VEHICLES RESULTS

WITHOUT CORRECTIVE LENSES:		WITH CORRECTIVE LENSES:	
Right Eye	20 / _____	Right Eye	20 / _____
Left Eye	20 / _____	Left Eye	20 / _____
Both Eyes	20 / _____	Both Eyes	20 / _____

TESTED ON WALL CHART: ☐ YES ☐ NO

☐ **APPLICANT FAILED TO COMPLY WITHIN 30 DAYS.**

NOTE TO PHYSICIAN: In accordance with the provisions of R. S. 40:1356, a health care provider is exempt from any liability as a result of reporting to the Department of Public Safety and Corrections any visual ability, physical condition, impairment or disability which may impair a person's ability to exercise ordinary and reasonable control in the operation of a motor vehicle. This form must be completed in its entirety by the physician and must reference any illness in the History section as well as why this form was issued. Incomplete forms may be rejected and could result in the denial of this applicant's driving privileges.

2. TO BE COMPLETED BY THE PHYSICIAN

HISTORY

1. Patient's Name: _____ Date of Birth: _____
2. Does patient have any medical or physical disorders? _____ If yes, list the medical or physical disorders _____
   _____
3. Is patient taking any medication? _____ If yes, **list current medication and dosage** _____
   _____
4. Has patient had any past surgical procedures? _____ If yes, list the past surgical procedures _____
   _____
   _____
   _____
5. Has patient had any illness that could affect the ability to operate a motor vehicle safely?_____ If yes, describe the illness _____
   _____
6. Has patient's driving privileges ever been withdrawn for a medical or physical disorder? _____

ORTHOPAEDIC

1. Does patient have any amputation or skeletal deficits that could interfere with the ability to operate a motor vehicle safely? _____ If yes, describe the deficits in detail _____
   _____
2. Does patient have stiff or frail joints? _____ If yes, describe _____
   _____
3. Does patient have spastic or paralyzed muscles? _____ If yes, describe _____
   _____
4. Does patient have any orthopedic appliances or supports? _____ If yes, list any device or support and how long used?
   _____
5. Does this device provide adequate compensation for operating a motor vehicle safely? _____

HEARING

1. Does the patient have any hearing impairment? _____ If yes, is the patient considered to be deaf or hard of hearing? _____
2. Is a hearing aid worn? _____ If yes, does it give sufficient correction? _____

CARDIOPULMONARY

1. Does patient have angina?_____ If yes, when does it occur?_____strenuous activity_____normal activity_____at rest_____
2. Does patient have dyspnea?_____If yes, when does it occur?_____strenuous activity_____normal activity_____at rest_____
3. Does patient have syncope?_____if yes, what is the frequency?_____duration_____last occurrence_____
4. Does patient have dizziness?_____ describe_____
5. What is patient's blood pressure? 1st reading _____ 2nd reading _____
6. What is patient's pulse? Rate _____ Rhythm _____
7. Has patient had cardiovascular catheterization or surgery? _____ If yes, describe _____

List medications and dosage: _____

NEUROLOGICAL

1. Does patient have epilepsy? _____If yes, what type of seizures? _____ Date of last seizure? _____
   Are seizures completely controlled? _____ Is patient under regular medical care? _____
   What are the anticonvulsant serum blood levels? _____
2. Does patient have any signs of Parkinsonism? _____ If yes, describe condition and severity _____
   Is coordination normal? _____ If no, describe _____
3. Does patient have any neurological disorder? _____ If yes, describe _____

List medications and dosage: _____

Is patient reliable in taking medication and following medical regimen? _____

MENTAL

1. Does patient have symptoms of any mental disorder? _____ If yes, describe condition and severity at present _____
2. Has patient ever been treated in a mental hospital? _____ If yes, where and when _____
   What was diagnosis and cure? _____
3. Does patient use alcohol or drugs? _____ If yes, describe usage _____
4. Is patient mentally deficient? _____ If yes, what was highest grade attained in school? _____ Age at attainment? _____
5. Does patient have sufficient regard for his/her personal safety as well as that of others to operate a motor vehicle safely? Give details _____
6. Is patient likely to act on sudden impulse without regard for the consequences of his/her behavior? _____ Give details _____
7. On the basis of your examination and/or knowledge of this patient, do you recommend periodic psychiatric examinations? Give details _____

List medications and dosage: _____

DIABETES

1. Does patient have a history of diabetes? _____ If yes, is insulin taken? _____ is oral medication taken? _____
2. What are patient's laboratory studies? recent urine sugars _____ recent blood sugars _____
3. Has patient had any occurrences of diabetic coma? _____ If yes, give dates _____
4. Has patient had any occurrences of insulin shock? _____ If yes, give dates _____
5. Does patient have associated abnormalities? visual_____renal_____vascular_____neurological_____other_____ If yes, describe _____
6. Does patient have hypoglycemia? _____ If yes, describe treatment _____

List medications taken and dosage: _____

7. Is patient reliable in taking diabetes medication?_____ Is diabetes controlled? _____

3. TO BE COMPLETED BY OPTOMETRIST OR OPHTHALMOLOGIST

VISION

WITHOUT CORRECTIVE LENSES	WITH CORRECTIVE LENSES	WITH NEW Rx
Right Eye 20/ ___	Right Eye 20/ ___	Right Eye 20/ ___
Left Eye 20/ ___	Left Eye 20/ ___	Left Eye 20/ ___
Both Eyes 20/ ___	Both Eyes 20/ ___	Both Eyes 20/ ___

PERIPHERAL VISION FIELDS: Left_____ Right_____

ANGLE OF VISION:	Temporal	Nasal	Temporal	Nasal

1. Can applicant recognize and distinguish among traffic control signals and devices showing standard red, green and amber Colors? ☐ Yes ☐ No
2. In your opinion, should the patient wear corrective lenses to operate a motor vehicle? ☐ Yes ☐ No
3. Is there evidence of eye disease or injury that would affect the driving ability? _____ If so, describe _____
4. In your opinion, should the patient be restricted to "Daylight driving only"? ☐ Yes ☐ No
5. Do you recommend that an operator's license be denied on visual grounds? _____ If so, what grounds? _____

4. TO BE SIGNED BY THE PATIENT

I hereby authorize the examining physician whose signature appears above to release all information and findings contained herein to the Louisiana Department of Public Safety and Corrections. The Louisiana Department of Public Safety and Corrections can release this information to such individuals or groups as may be considered necessary and appropriate to determine my ability to safely operate a motor vehicle.

Date_____ Signature of Patient _____

5. TO BE COMPLETED, SIGNED AND DATED BY THE PHYSICIAN (MEDICAL) OR OPTOMETRIST/OPHTHALMOLOGIST (VISION)

PLEASE REFER TO "NOTE TO PHYSICIAN:" on the first page of this form. Are you this patient's treating physician? _____

In your opinion, from a medical/vision standpoint, is it safe for this patient to operate a motor vehicle? _____

On the basis of your examination and/or knowledge of this patient, do you recommend periodic medical/vision reports be submitted? _____

If yes, how often? ☐ 6 months ☐ 1 year ☐ 2 years ☐ other_____ Remarks: _____

_____

Physician's Signature _____ Date _____

Physician's Printed Name _____ Telephone# _____

Physician's Address _____