Attachment B

DR 2401 (11/28/05)
COLORADO DEPARTMENT OF REVENUE
DIVISION OF MOTOR VEHICLES
DRIVER CONTROL SECTION
DENVER, CO 80261-0016

CONFIDENTIAL MEDICAL /EYE EXAMINATION REPORT

For confidential use of the DMV in making decisions on the individual's (Named Below) qualifications as a driver. This opinion shall only be divulged to the applicant or driver or in a trial or proceeding concerning the individual's qualifications to receive or retain a driver's license. (Section 42-2-111 and 42-2-112, C.R.S.)

UNLESS OTHERWISE STATED, THIS REPORT MUST BE RETURNED TO THE OFFICE WHERE INITIAL APPLICATION WAS MADE.

Date	Office	Office Number	Examiner

Name of Applicant (Print)	Date of Birth

Address

Current License Number (OPTIONAL)	State

SECTION I: AUTHORIZATION TO ATTENDING PHYSICIAN/OPTOMETRIST

TO (Physician/Optometrist) _____

Note: Physician please complete Sections II and III below. Optometrist please complete Sections IV and V on the reverse side.

I, _____ hereby authorize the above named physician/optometrist to give the Colorado Department of Revenue, or its representative, any information he/she may have regarding my condition when under his/her observation or treatment.

Applicant's signature _____ Date _____

SECTION II: PHYSICIAN'S REPORT OF MEDICAL EXAMINATION

1. **From your assessment of the medical history, physical examination and laboratory data, and in consideration of public safety, would authorization of a driving privilege be medically prudent?** ☐ **Yes** ☐ **No** **Road test required** ☐ **Yes** ☐ **No** ☐ **Rehab Permit Only**
   If it is not prudent to authorize a driving privilege- *NO* road test will be given .
2. What medical restrictions and/or prostheses are necessary for the above named applicant to operate a motor vehicle? (This approved medical report is contingent upon the following indicated restriction(s) appearing on applicant's instruction permit and/or driver's license. Failure to comply will result in the cancellation and denial of applicant's driving privilege.)

REMARKS _____

Physician Name (Please Print): _____ Title: _____

Signatnature _____ Current Date of Evaluation: _____

Address: _____ Telephone Number: _____

City_____ State_____ ZIP code_____

SECTION III: REPORT OF MEDICAL EXAMINATION

PHYSICIAN The information requested herein will be used to evaluate the driving abilities of the applicant. The final determination of this risk, if any, depends on your prompt and accurate completion of this form. **NOTE:** As provided by law, licensed physicians and optometrist are immune from civil and criminal action if they act in good faith and without malice 42-2-112 C.R.S. The physician assumes no responsibility in making this report other than that of representing the facts as they appear from this professional examination. Your medical remarks will be held in confidence.

HEARING (If impaired)	Right Ear	Left Ear	VISION	BLOOD PRESSURE
Whispered voice, standing sideways with distant ear closed.	_____ Ft.	_____ Ft.	Best corrected vision, both eyes open 20/ _____	

No.	Check each item in appropriate column (Enter NE, if not evaluated)	NORMAL	ABNORMAL	NOTES Describe every abnormality in detail. Enter applicable item numbers before each comment. Use additional sheet if necessary and attach to this form.
1	HEAD, FACE, NECK			
2	HEART			
3	LUNGS			
4	EXTREMITIES			
5	MUSCULO-SKELETAL			
6	ENDOCRINE Diabetes			
7	NEUROLOGIC			
8	PSYCHIATRIC Serious Neurosis Psychosis Serious Personality Deviation			
9	OTHER			

10 Does history indicate seizures or lapses of consciousness? ☐ Yes ☐ No If yes, continue to complete question No. 11

11 Date of onset _____ Frequency _____ Dates of last two seizures or lapses _____

Describe any seizures/lapses of consciousness _____

Probable diagnosis _____

SECTION IV: EYE EXAMINATION REPORT

1. **From your assessment of the visual history, visual examination and laboratory data, and in consideration of public safety, would authorization of a driving privilege be medically prudent?** ☐ Yes ☐ No
   If it is not prudent to authorize a driving privilege, NO road test will be given.
   Road test Required? ☐ Yes ☐ No

Special Restrictions:

☐ Daylight driving only. ☐ Area Radius _____ Miles from home

☐ Not more than _____ MPH ☐ Right Sideview Mirror ☐ Left Sideview Mirror

☐ Other _____

Optometrist's Name (Please Print): _____ Title: _____

Signature: _____ Date of Evaluation: _____

Address: _____ Telephone Number: _____

SECTION V: REPORT ON EXAMINATION OF EYE CONDITION

ACUITY (Check appropriate boxes)	Both	Right	Left
Without Correction	20/ _____	20/ _____	20/ _____
With Glasses	20/ _____	20/ _____	20/ _____
With Contact Lenses	20/ _____	20/ _____	20/ _____
Bioptic Lenses	20/ _____	20/ _____	20/ _____
Carrier Lens	20/ _____	20/ _____	20/ _____

COORDINATION: PHORIAS (To be measured at 20 feet)

Horizontal Exo _____ Eso _____

Vertical: R Hyper _____ L Hyper _____

FUSION: ☐ Excellent ☐ Good ☐ Poor ☐ None

DEPTH PERCEPTION: ☐ Excellent ☐ Good ☐ Poor ☐ None

FIELDS - HORIZONTAL PERCEPTION FIELDS:

RIGHT _____ LEFT _____ ☐ Pass ☐ Deficient ☐ Fail

COLOR: Traffic Lights, Holmgren, Ishihara, Edrige, Nagel, or

Other _____

RESPONSE TO LIGHT: (Please furnish if testing equipment is available)

Pupillary reflex Right _____ Left _____

Glare resistance Right _____ Left _____

Glare recovery Right _____ Left _____

INJURY OR DISEASE
(Please describe fully)

_____

_____

_____

I understand that this form will be considered in any decision regarding the issuance of my driver's license.

Signature: _____ Date _____