

PLEASE RETURN COMPLETED  
VISION FORM TO:  
PH: (785) 368-8971  
FAX: (785) 296-5857  
WEBSITE: KSREVENUE.GOV

STATE OF KANSAS DIRECTOR OF VEHICLES  
MEDICAL/VISION UNIT  
300 SW 29th ST.  
PO BOX 12021  
TOPEKA KS 66601-2021

KANSAS DIVISION OF VEHICLES VISION FORM

GENERAL INFORMATION & HISTORY – TO BE FILLED OUT BY THE PATIENT

Name: \_\_\_\_\_ Driver's License #: \_\_\_\_\_ DOB: \_\_\_\_\_  
Address: \_\_\_\_\_ CITY/STATE/ZIP: \_\_\_\_\_  
Phone Number: \_\_\_\_\_  
Currently enrolled in Driver's Education? YES / NO If yes, instructor name & phone number: \_\_\_\_\_

RELEASE OF INFORMATION – TO BE FILLED OUT BY THE PATIENT

Permission is granted for release of all vision information concerning me to the Kansas Division of Vehicles by all vision and vision/medical professionals filling out this form. Minors may sign/date their own form or their Guardian may sign/date the form if the Minor is under 18 years of age.

\_\_\_\_\_  
SIGNATURE OF PATIENT or GUARDIAN (if patient under 18 years of age) DATE

SECTION I: VISION REPORT – TO BE FILLED OUT BY THE VISION PROFESSIONAL (K.S.A 8-295, 8-255c/K.A.R. 92-52-12)

The information on this form must be from an examination within the past 90 days (8-241(a)(1)).

	<u>Distance Acuity</u> <u>Right Eye</u>	<u>Distance Acuity</u> <u>Left Eye</u>	<u>Horizontal Field of Vision (in degrees)</u>
Visual Acuity Without Glasses/Contacts	20/_____	20/_____	Right Eye: _____
Visual Acuity With Glasses/Contacts	20/_____	20/_____	Left Eye: _____
Biopic/Telescopic (for vision professional use)	20/_____	20/_____	

(Biopic/Telescopic readings are not used to determine issuance or drive test requirements)

Vision Condition Diagnosis: \_\_\_\_\_

Vision Condition Prognosis: \_\_\_\_\_

Provider Comments: \_\_\_\_\_

- An annual vision report is recommended due to vision condition.
- |  |                              |                             |
|--|------------------------------|-----------------------------|
| Does the driver require adaptive equipment to drive?                             | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you recommend a drive test or driver education (if not licensed)?             | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you recommend this patient have a medical exam?                               | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you recommend a Kansas Medical Advisory Board review be completed?            | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you recommend this patient have a medical exam for an intellectual diagnosis? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Does this driver have a Cortical Visual Impairment (CVI) diagnosis?              | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
- Additional testing for CVI is recommended to assess visual processing impairment.
  - Please print and attach CVI testing results to this form.

Indicate below which restrictions may apply to the patient's license if issued or continued: **Maximum 6 restrictions. Driver must use glasses or contacts for driving to add Corrective Lenses. To remove a restriction(s) previously requested by a vision professional, please check the restriction box, and write "R" beside it.**

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Corrective Lenses  | <input type="checkbox"/> Daylight Hours Only           | <input type="checkbox"/> No Interstate Driving                             | <input type="checkbox"/> Outside Business Area |
| <input type="checkbox"/> Within City Limits | <input type="checkbox"/> Licensed Driver in Front Seat | <input type="checkbox"/> Automatic Transmission                            | <input type="checkbox"/> Outside Mirror        |
| <input type="checkbox"/> Mechanical Aid     | <input type="checkbox"/> Prosthetic Aid                | <input type="checkbox"/> _____ Miles From Home (5-30 in 5 mile increments) |  |

\_\_\_\_\_  
Name of Vision Professional (please print) & Specialty

\_\_\_\_\_  
Date of Examination (must be within past 90 days or 6 months post seizure, or consciousness occurrence)

\_\_\_\_\_  
Address

\_\_\_\_\_  
Signature of Vision Professional

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Date Signed