

Our Ref:
Date:

ACUITY OF VISION

ACUITY OF VISION IS REQUIRED IN RESPECT OF:
WHO HAS APPLIED FOR ORDINARY/VOCATIONAL DRIVING ENTITLEMENT.

NOTE: Visual acuities must be measured by Snellen chart

i) Please state the unaided visions
without corrective lenses:

ii) Acuties corrected by lenses:

RIGHT:

LEFT:

RIGHT:

LEFT:

- | | YES | NO |
|--|--------------------------|--------------------------|
| A WERE THE ACUITIES TAKEN WITH THE APPLICANT'S CURRENT GLASSES? | <input type="checkbox"/> | <input type="checkbox"/> |
| B WAS A NEW RX REQUIRED TO ACHIEVE THESE STANDARDS? | <input type="checkbox"/> | <input type="checkbox"/> |
| C HAS THE NEW RX BEEN DISPENSED? | <input type="checkbox"/> | <input type="checkbox"/> |
| D DOES THE APPLICANT'S FIELD OF VISION BY HAND TEST COMPLY WITH THE MEDICAL ASPECTS OF FITNESS TO DRIVE?

(i.e. with a field of at least 120° on the horizontal and no significant defect in the binocular field which encroaches within 20° of fixation above or below the horizontal meridian.) | <input type="checkbox"/> | <input type="checkbox"/> |
| E DOES THE APPLICANT SUFFER FROM DOUBLE VISION?
IF YES PLEASE GIVE DETAILS OVERLEAF. | <input type="checkbox"/> | <input type="checkbox"/> |
| F IF THE APPLICANT'S VISION CANNOT BE CORRECTED BETTER THAN 6/12 (BINOCULAR) CAN THEY SATISFY A REPLICA EXTERNALLY ILLUMINATED NUMBER PLATE TEST (Vision test for Motor Vehicle Drivers) WHICH IS EQUIVALENT TO 6/10 BINOCULARLY? | <input type="checkbox"/> | <input type="checkbox"/> |

SIGNED: _____ DATE: _____

Signature of Registered OPTICIAN

Stamp (of the Registered OPTOMETRIST)
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Applicant's Signature: _____ Date: _____

PLEASE SIGN IN THE PRESENCE OF EXAMINING OPTOMETRIST

N.B. APPLICANT MUST COMPLETE DECLARATION ON THE BACK OF THIS FORM.

DECLARATION OF CONSENT BY APPLICANT:

I

DOB ___/___/___

OF

Authorise my doctor(s) and specialist(s) to release reports to DVLNI's Medical Advisors about my medical condition.

I authorise DVLNI to disclose relevant medical information about me to Doctors or Paramedical staff as necessary in the course of medical enquiry into my fitness to drive.

I also authorise the Medical Advisor to advise the Department of Environment (NI) on my fitness to drive any type of vehicle.

Signature: _____ **Date:** ___/___/___.

- **Please note that further medical information may be required to enable a recommendation on fitness to drive to be made.**