Evaluation Date: _____

Time: _____

Location: _____

KENTUCKY DEPARTMENT OF VOCATIONAL REHABILITATION
DRIVER REHABILITATION TECHNOLOGY SERVICES

REFERRAL FORM

CONSUMER INFORMATION

REFERRAL DATE: _____

NAME: _____

PHONE: _____

ADDRESS: _____

CITY/COUNTY: _____

STATE: _____ ZIP: _____

SOC. SEC. NO: _____ DOB: _____

DISABILITY: _____

_____

COMMENTS: _____

_____

_____

REFERRAL SOURCE INFORMATION

NAME: _____

PHONE: _____

ADDRESS: _____

CITY/STATE: _____ ZIP: _____

SERVICES REQUESTED

DRIVER EVALUATION: ☐ VEHICLE MODIFICATION (First Time): ☐

DRIVER TRAINING: ☐ VEHICLE MODIFICATION (Replacement): ☐

COMMENTS: _____

_____

_____

ENCLOSE THE FOLLOWING DOCUMENTS

- ◊ PHYSICIAN CONSENT FOR DRIVER REHABILITATION SERVICES
- ◊ CONSUMER CONSENT FOR DRIVER REHABILITATION SERVICES
- ◊ COPY OF VALID DRIVER'S LICENSE OR LEARNER'S PERMIT
- ◊ COPY OF SIGNED DVR-2 (WHEN APPLICABLE)
- ◊ VISUAL
- ◊ ANY OTHER INFORMATION THAT COULD BE PERTINENT TO DRIVER REHABILITATION SERVICES (MEDICAL EVALUATIONS, DISCHARGE SUMMARIES, VOCATIONAL EVALUATIONS, PSYCHOLOGICALS)

FOR OFFICE USE ONLY

DDL CONTACT DATE: _____ EXPIRES: _____

COMMENTS: _____

_____

SPECIALIST: _____

DATE ASSIGNED: _____ DATE SCHEDULED: _____

TIME: _____ LOCATION: _____

OVER

KENTUCKY DEPARTMENT OF VOCATIONAL REHABILITATION
DRIVER REHABILITATION TECHNOLOGY SERVICES

PHYSICIAN'S CONSENT FORM

NAME: _____

The above named person has requested to participate in a driver rehabilitation technology evaluation. The evaluation will be conducted by a Driver Rehabilitation Specialist from the Kentucky Department of Vocational Rehabilitation. The Physician's Consent is not the final determining factor for the person to have a driver's license. The final decision will be made by Division of Driver License.

Diagnosis: _____

Medications: _____

_____

Seizures within the last 90 days ☐ Yes ☐ No

Spasms ☐ Yes ☐ No Controlled? ☐ Yes ☐ No

Are there any other signs of Neurological Disorder? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

OVER

Based on my examination, this person is in an appropriate medical status to participate in a driver rehabilitation services assessment.

YES ☐ NO ☐

COMMENTS _____

_____

_____ _____

Physician's Signature Date

NAME OF PHYSICIAN: _____

ADDRESS: _____

CITY/STATE: _____ ZIP: _____

RETURN FORM TO REFERRAL SOURCE

NAME: _____

ADDRESS: _____

CITY/STATE: _____ ZIP: _____

KENTUCKY DEPARTMENT OF VOCATIONAL REHABILITATION
DRIVER REHABILITATION TECHNOLOGY SERVICES

CONSUMER CONSENT FORM

I authorize release of any medical, psychological, visual, educational, and/or other pertinent information that would assist in determining my ability to operate a motor vehicle to the Department of Vocational Rehabilitation, Driver Rehabilitation Technology Services.

I realize that driver evaluation/education/vehicle modification may present special risks to me and I voluntary assume such risks in order to participate in this program. As a result, I release and hold harmless the Commonwealth of Kentucky, Cabinet for Workforce Development, Department of Vocational Rehabilitation and/or any of its employees.

I also understand that participation in the Driver Rehabilitation Technology Services depends on the consent of my physician with final determination of my eligibility to hold a valid driver's license to be made by my resident state's Division of Driver License.

_____ _____
Consumer's Signature **Date**

_____ _____
Parent's Signature (if for person under age 18 years) **Date**

RETURN FORM TO REFERRAL SOURCE

NAME: _____

ADDRESS: _____

CITY/STATE: _____ ZIP: _____

OVER

DVR-3b
(Revised 1/91)

COMMONWEALTH OF KENTUCKY
CABINET FOR WORKFORCE DEVELOPMENT
DEPARTMENT OF VOCATIONAL REHABILITATION

MEDICAL REPORT
Visual Disability

To Examiner: Please send completed report to: _____

_____

Name of patient: _____ Address: _____

_____

SECTION I – REPORT OF EXAMINATION

VISUAL ACUITY – Snellen notations (20 feet for distance; 14 inches for reading).

1. Distance: (a) Without glasses: (b) With best correction: (c) Percentage loss – with best correction

   R _____ R _____ R _____%

   L _____ L _____ L _____%

2. Reading: (a) Without glasses: (b) With best correction: (c) Percentage loss – with best correction

   R _____ R _____ R _____%

   L _____ L _____ L _____%

3. Refraction record: (a) Sphere: (b) Cylinder: (c) Axis

   R _____ R _____ R _____%

   L _____ L _____ L _____%

(d) Is difference in spherical correction of the two eyes more than 3 diopters? _____

VISUAL FIELD: (Do not make detailed test unless indicated by preliminary test) Normal _____ Restricted _____

If restricted, or if scotomata are present, chart on back of form and describe under pathology.

MUSCLE FUNCTION: (Do not make detailed test unless indicated by preliminary test.) Normal _____ Restricted _____

If restricted, chart the motor field on back of form and describe under pathology.

BINOCULAR FUNCTION:

1. Does patient have useful binocular vision in all directions – with glasses?

   For distance _____ For near _____

2. If patient does not have useful binocular vision, give reason and explain any handicap arising therefrom

   _____

   _____

   _____

   Is depth perception present? _____

OVER

SECTION I – REPORT OF EXAMINATION - Continued

COLOR PERCEPTION: Normal _____ Color Blind _____

If color blind, for what colors? _____

WASSERMAN REPORT – Results, if secured _____

SECTION II – DIAGNOSIS

1. Eye Pathology (Primary and Secondary conditions) _____

2. Primary and contributory causes of condition _____

3. Characteristics of condition (check): Stable _____ Progressive _____ Improving _____
Recurrent _____ Permanent _____ Communicable _____

SECTION III – PROGNOSIS AND RECOMMENDATIONS

1. Prognosis as to future developments of condition _____

2. Treatment recommended – medical or other therapy _____

3. Are glasses recommended? _____ If so, please attach prescription.

3. Precautions that should be taken in training or placement of patient in employment:

(a) As to types of activity to be avoided _____

(b) As to working conditions to be avoided _____

Remarks: _____

Place _____ _____
(Signature of examiner)

Date _____

OVER

TABLES AND CHARTS

NOTE - The tables below are on the basis of examination at 20 feet for distant and 14 inches for near vision. If the patient's eye condition is such that examination cannot be made at these distances, the distance at which it is made should be shown with the distance at which a person having normal vision would be able to see the same test letters or characters, and the percentage loss should be calculated therefrom.

1. Table of Percentage LOSS of Visual Efficiency Corresponding to Snellen Notations for Distance and for Reading (American Medical Association Standard s) and to Jaeger Reading Test Card

FOR DISTANCE	FOR READING			FOR DISTANCE	FOR READING		
At 20 Feet Snellen Notations AMA Chart	At 14 Feet Snellen Notations AMA Chart	By Test on Jaeger Card	Percentage Loss	At 20 Feet Snellen Notations AMA Chart	At 14 Feet Snellen Notations AMA Chart	By Test on Jaeger Card	Percentage Loss
20/20	14/14	No. 1	No Loss	20/90	14/63		46.6
20/25	14/17.5		4.3	20/100	14/70	No. 11	51.1
20/30	14/21	No. 2	3.5	20/110			55.0
20/35	14/24.5	No. 3	12.5	20/120	14/84	No. 12	60.1
20/40	14/26	No. 4	16.4	20/140	14/96	No. 14	65.8
20/45	14/31.5	No. 5	20.0	20/160	14/112	No. 16	71.4
20/50	14/35	No. 6	23.5	20/200	14/140	No. 17	80.0
20/60	14/42	No. 8	30.0	20/240	14/168	No. 18	87.0
20/70	14/49	No. 9	35.0	20/320	14/224	No. 19	92.8
20/80	14/56	No. 10	41.5	20/480	14/336	No. 20	98.0

2. Table of LOSS in Binocular Vision (Motor-Field Efficiency)

EXTENT OF LOSS	MOTOR-FIELD EFFICIENCY	EXTENT OF LOSS	MOTOR-FIELD EFFICIENCY
	Percent		Percent
No loss	100	11/20	67
1/20	98	12/20	63
2/25	95	13/20	59
3/30	92	14/20	55
4/35	89	15/20	50
5/40	87	16/20	45
6/45	84	17/20	39
7/50	81	18/20	32
8/60	77	19/20	22
9/70	74	20/20	0
10/80	71		

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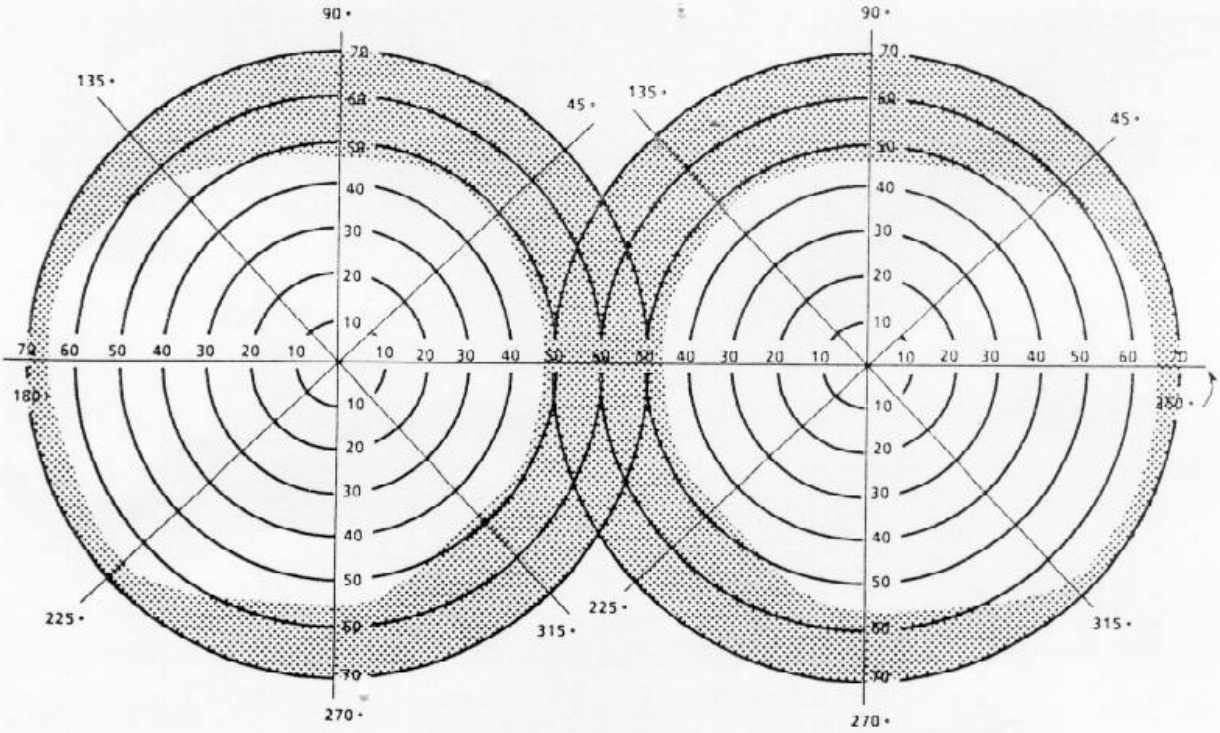
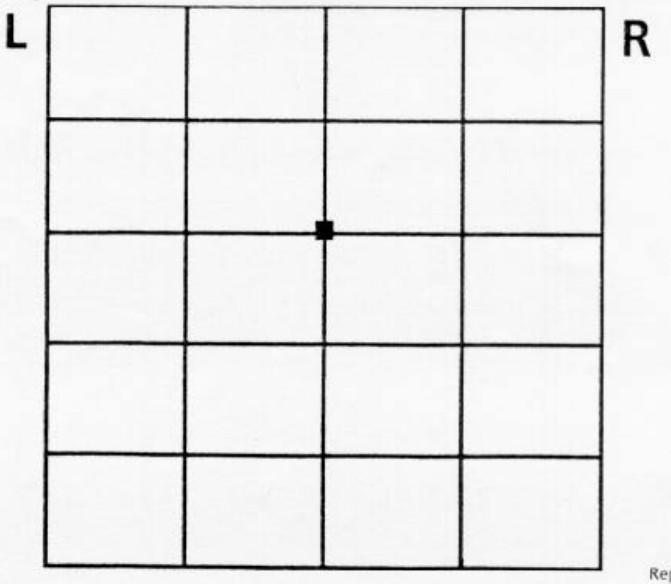
3. CHART OF VISUAL FIELD

(NOTE — Visual field should be tested on a standard perimeter having a radius of 11 inches, white test object of 6 millimeters diameter.)



4. CHART OF MOTOR FIELD

(NOTE — Motor-field test chart should be 42 inches by 42 inches divided into rectangles approximately 10.5 inches by 8.5 inches. Test at 10 feet.)



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