STATE OF FLORIDA
DEPARTMENT OF HIGHWAY SAFETY
AND MOTOR VEHICLES

Prism Form

RE: _____
DL#: _____
DOB: _____

Dear Physician:

According to our records, this individual wears prisms. We are in the process of assessing his/her ability to safely operate a motor vehicle and need your input on the following questions:

1) What is the patient's current diagnosis and the reason prism(s) are prescribed?

2) Is there a paretic muscle involved? If yes, which one?

3) Is the prism used for correcting a hemianopsia?

4) What kind of prism is the patient currently wearing? (Please provide a description of the location and power of the prism and whether it is on one lens or both.)

5) How long has the patient been wearing the prism(s)?

6) In your opinion, has the patient adapted to the prism(s) well enough to operate a motor vehicle safely while wearing them? Yes: _____ No: _____

Comments: _____

_____

_____

Mail this Completed Form to:
Bureau of Motorist Compliance
Medical Review Program
Neil Kirkman Building, MS 86
Tallahassee, Florida 32399-0500
Telephone No.: (850) 617-3814
Fax No.: (850) 617-3944

Signature of Physician: _____

Print Physician's Name: _____

Medical License #: _____

Address: _____

Telephone Number: _____

Date: _____