NOVA SCOTIA

Service Nova Scotia and Municipal Relations
Motor Vehicle Administration

1505 Barrington Street
9 North
Halifax, Nova Scotia
B3J 3K5
Tel: (902) 424-5732
Fax: (902) 424-0772

Eye Examination

This form must be completed by an Optometrist or Ophthalmologist.

Patient Information and Consent

Name: ______________________ Date of Birth: ______________________

Address: ______________________ Telephone: Home ( ) ____________ Work ( ) ____________

______________________ Postal Code: ____________ Cellular ( ) ____________

Master No: ______________________ Class of licence *(check one)*: ① ② ③ ④ ⑤ ⑥ ⑦ ⑧

I authorize a vision specialist to report their findings to the Motor Vehicle Administration Section.

______________________ PATIENT'S/DRIVER'S SIGNATURE

______________________ DATE

I, ______________________, being licensed to practice ophthalmology/optometry in the Province of Nova Scotia, have examined the person named above and find the following:

For classes **3**, **5**, **6**, **7** and **8**, visual acuity must be at least **20/40** (**6/12**) in better eye.

For classes **1**, **2**, and **4**, visual acuity must be at least **20/30** (**6/9**) in better eye and **20/50** (**6/15**) in poorer eye.

VISUAL ACUITY	Right eye	Left eye
Vision uncorrected *(Snellen Chart)*		
Vision with correction *(Snellen Chart)*		

Colour vision *(can accurately identify red, green and amber)* ❑ Yes ❑ No

Any diplopia? ❑ Yes ❑ No

Is there evidence of eye disease or injury? ❑ Yes ❑ No

If "Yes," please provide diagnosis/condition ______________________

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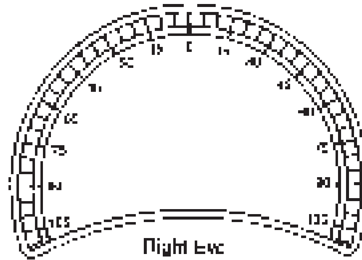
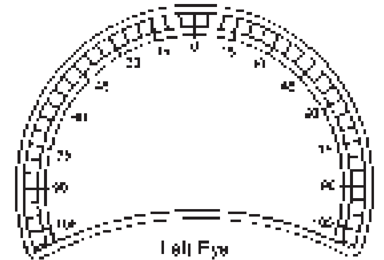
VISUAL FIELD

For classes **3**, **5**, **6**, **7** and **8**, visual field must be at least **120°** with **both eyes** opened and examined together.

For classes **1**, **2**, and **4**, visual field must be at least **120°** in **each eye** examined separately.





Any visual field defects? ❑ Yes ❑ No

If "Yes," please explain ______________________

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Does this patient meet the vision standards required to safely operate the class of motor vehicle as checked above? ❑ Yes ❑ No

Does patient: need corrective lenses for driving? ❑ Yes ❑ No need a daylight driving only restriction? ❑ Yes ❑ No

have the recommended correction? ❑ Yes ❑ No

Is follow up required? ❑ Yes ❑ No If yes, when ______________________

Ophthalmologist/Optometrist's Information

Address: ______________________

City/Town: ______________________ Province: ______________________ Postal Code: ______________________

Telephone: ( ) ______________________ Fax: ( ) ______________________

______________________ OPHTHALMOLOGIST/OPTOMETRIST'S SIGNATURE

______________________ DATE