|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 11 Calle 15-62 Zona 13 | | **INTEVISA** |  | 2 | logocompleto |
|  |  | CERTIFICADO |  | |
|  | DE EXAMEN DE LA VISTA – AGUDEZA VISUAL – | | | |
| Este certificado tiene validez por 6 meses a partir de la fecha de su emisión. No debe llevar tachones, borrones ni correcciones. | | | | | |
| *EL PRESENTE FORMULARIO DEBERIA SER LLENADO UNICAMENTE A MÁQUINA DE ESCRIBIR O COMPUTADORA* | | | | | |
| viernes, 4 de noviembre de 2022 | | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **DATOS DEL PROFESIONAL** | |  |  |
|  | | | |
| **Ramiro Faillace Poggio** | | |  |
|  | | | |
| NUMERO DE REGISTRO EN EL DEPARTAMENTO DE TRANSITO | | 070213 |  |
|  | | | |
| NUMERO DE REGISTRO EN EL MINISTERIO DE SALUD | | 404 |  |
|  | | | |
| NUMERO DE REGISTRO EN LA ASOCIACION GUATEMALTECA DE OFTALMOLOGIA | |  |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CERTIFICA QUE** | | | | | | | | |  |  |
| NOMBRE COMPLETO DEL PACIENTE: | |  | | | | | | | |  |  |
| nombreUNO apellidoUNO | | | | | | | | | |  |  |
|  | | | | | | | | | | |
| DPI, CÉD. DE VECINDAD O PARTIDA DE NACIMIENTO: | | | | | | | | | |  |
| 1111111111111 | | | | | | | | | |  |
|  | | | | | | | | | | |
| FECHA DE NACIMIENTO |  | | | SEXO | | | | | |  |
| 4/11/2022 | |  | | | **X** | **F** |  | **M** |  |  |
|  | | | | | | | | | | |
| DEPARTAMENTO |  | | MUNICIPIO | | | | | | |  |
| Alta Verapaz | |  | | | Cobán | | | | |  |
|  | | | | | | | | | | |  |
| RESIDENCIA DOMICILIAR (DIRECCIÓN EXACTA) | | | | | | | | | |  |
| 1111111111111111111111111111111111111111 | | | | | | | | | | | |

**Obtuvo los siguientes RESULTADOS CLINICOS del examen de Agudeza Visual:**

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| --- | --- | --- | --- | --- |
| ***AGUDEZA VISUAL*** | | | | |
|  | | | | |
| 20/25 |  | 20/25 |  | 20/25 |
| O.D. |  | O.I. |  | O.U. |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| ***VISION DE COLORES*** | | |  | ***SENSIBILIDAD DE CONTRASTES*** | | |
|  | | |  | | |
|  |  | X |  |  | X |
| Normal |  | Deficiente | Normal |  | Deficiente |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ***CAMPO VISUAL CENTRAL EN GRADOS*** | | | | |  | ***CAMPO VISUAL PERIFERICO EN GRADOS*** | | | | |
|  | | | | |  | | | | |
| O.D. | 20 |  | O.I. | 20 | O.D | 85 |  | O.I. | 85 |
|  | | | | |  | |  |  | |
|  | |  | X | |  | |  | X | |
| Normal | |  | Deficiente | | Normal | |  | Deficiente | |

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| --- | --- | --- | --- | --- | --- | --- |
| ***PRUEBA ESTEREOSCOPIA PARA VISION LEJANA*** | | |  | ***>= A 600 SEG*** | | |
|  | | |  | | |
|  |  | X |  |  | X |
| Si hay estereopsis |  | No hay estereopsis | Si |  | No |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| ***USA ANTEOJOS*** | | |  | ***USA LENTES DE CONTACTO*** | | |
|  | | |  | | |
|  |  | X |  |  | X |
| Si |  | No | Si |  | No |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| En base a los parámetros de visión autorizados por el Departamento de Transito, el paciente se encontró apto para obtener licencia de conducir: | | | | | | | | | | | | |
|  |  |  |  |  |  |  |  |  |  | X |  | 1111111111111111111111 | |
| A |  | B |  | E |  | C |  | M |  | Ninguna |  |

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