Centre de réadaptation
LETHBRIDGE-
LAYTON-MACKAY
Rehabilitation Centre

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DRIVING EVALUATION PROGRAM
REGISTRATION FORM

Motorcycle Driving Evaluation

Date of request: _____ (Year) _____ (Month) _____ (Day) CLRC record: _____

Information on applicant

Date of birth _____ (Year) _____ (Month) _____ (Day)

Name at birth: _____ Sex: ____ First name: _____

Medicare card number: _____ Exp. date: _____

Address: _____ City: _____

_____ Postal code: _____

Tel.: Home: _____ Email: _____

Work: _____ Language spoken: _____

Other: _____ Occupation: _____

Name of spouse: _____ First name: _____

Contact person: _____ Telephone: _____

Relationship to applicant: _____

Mother's name: _____ Father's name: _____

Source of referral

Source of referral: _____ Profession: _____

Name of establishment: _____ Signature: _____

Address: _____ Telephone: _____

_____ Postal code: _____

PLEASE ATTACH A SUMMARY OF THE MEDICAL RECORD (if possible)

Compensation from a specific program

❑ YES ❑ NO

❑ SAAQ (road accident) ❑ CSST (work accident) ❑ IVAC (victim of criminal act)

Counsellor name: _____ Tel.: _____

Record number: _____

Medical history

Primary diagnosis: _____

Date of accident / beginning of illness: _____ (Year) _____ (Month) _____ (Date)

Associated condition(s): (e.g. sensory, cognitive, perceptual, motor disabilities)
(if possible, attach an OT/physio report) _____

Medical history and treatments received: _____

Applicant's abilities/disabilities related to motorcycle driving and access: _____

Environmental/social context (e.g. lives alone, with family): _____

Medications: _____

Information on mobility aids

Can the applicant walk short distances without anyone's aid?

❑ YES ❑ NO

If yes, is a technical aid required for walking (e.g. cane, walker)? _____

Is a wheelchair required for getting around? ❑ YES ❑ NO

If YES, model: _____

Will the applicant need to bring a mobility aid along on the motorcycle?

❑ YES ❑ NO _____

Information on the motorcycle

Driver's license number:

(No. beginning with first letter of the family name: _____ Exp.: _____

Does the applicant own a motorcycle ? ❑ YES ❑ NO

If yes, what model/year: _____

Does the applicant currently drive this motorcycle? ❑ YES ❑ NO

Has this motorcycle already been adapted? ❑ YES ❑ NO

If yes, how: _____

If no, do you think the motorcycle should be adapted? ❑ YES ❑ NO

Proposed adaptations: _____

For what activities will the applicant use the motorcycle (recreation, work)? _____

Number of years of experience driving motorcycles: _____

Does the applicant currently drive a passenger vehicle (class 5)? ❑ YES ❑ NO

Current vehicle adaptations: _____

Has the applicant undergone a functional assessment by an occupational therapist for driving evaluation? ❑ YES ❑ NO

If yes, please attach the M-57 report on that driving evaluation.

❑ Other needs (specify): _____

Consent form

I, _____ , hereby give full consent to the Société de l'Assurance
(Name, in printed letters)

Automobile du Québec (SAAQ), my treating physician _____ , and the referral
(Physician's name)

source to send to the Constance Lethbridge Rehabilitation Centre all information required for my motorcycle driving evaluation and to share among them whatever information is required to ensure the quality of the services provided to me.

Signature: _____ **Date:** _____ _____ _____
Year Month Day

Witness: _____ **Date:** _____ _____ _____
Year Month Day

Has the original copy of the M-28 medical form been sent to the SAAQ? ☐ YES ☐ NO

IMPORTANT INFORMATION FOR THE APPLICANT IN PREPARATION FOR THE EVALUATION APPOINTMENT

- **Submit with this request an M-28 form (for motorcycle driving) completed by a physician**
- **Bring your driver's license**
- **Bring your prescription glasses, sunglasses, and appropriate helmet and clothing**
- **Bring a list of your medications**