Société de l'assurance automobile
Québec

28 Medical examination report by a general practitioner – Driver's licence

Fees that may be charged for completing this form must be paid by the examinee and do not qualify for reimbursement by the Société.

Send this form back to:
Société de l'assurance automobile du Québec
Service de l'évaluation médicale
C.P. 19500, Québec (Québec) G1K 8J5

Last name

First name

Address (Number, street, apartment) | Municipality | Postal code

Date of birth | Driver's licence number | Telephone (home) Area code | Telephone (work) Area code

At the top of each page of this form, please indicate the name, birthdate and driver's licence number (if known) of the person undergoing the medical examination.

PERSON UNDERGOING THE MEDICAL EXAMINATION

- **Read and sign the authorization below.**
- **Please read the statement regarding protection of personal information at the bottom of page 4.**

I, the undersigned, hereby authorize the Société de l'assurance automobile du Québec to discuss, when necessary, medical information concerning me with the physician who signs this form. I understand that a summary of all communications will be kept on file.

Signature of the person undergoing the medical examination: ____________________ Date: ______

Under sections 2840 and 2841 of the Civil Code of Québec, a photocopy or computer reproduction of this authorization carries the same value as the original.

PHYSICIAN

The examination must take into account prior and current ailments that may affect the individual's ability to drive. A list of relevant disorders is provided at the top of several sections. This is an aide-memoire and **any disorder that does not appear in the list must be indicated in section 10.**

____

____

VISION DISORDERS

1 *Glaucoma, cataract, abnormal visual field, etc.*

Provide any known diagnosis: ____________________

Visual acuity based on Snellen Chart: Without correction ▸ OU: 6/____ OS: 6/____ OD: 6/____ With correction ▸ OU: 6/____ OS: 6/____ OD: 6/____

- *Can be omitted if patient has been referred to an ophthalmologist or optometrist.*
- *"With correction" information is required only if glasses or contact lenses are necessary for driving.*

Confrontation field: ☐ Normal ☐ Abnormal **Diplopia:** ☐ Yes ☐ No

Check box if there is no health disorder to report in this section ☐

HEARING DISORDERS

2 *Hearing loss*

Diagnosis: ____________________

Hearing loss: ☐ Right ear ☐ Left ear

Check box if there is no health disorder to report in this section ☐

NEUROLOGICAL DISORDERS

3 *Parkinson's, MS, epilepsy, syncope, CVA/TCI, brain aneurysm, arteriovenous malformation, head trauma, brain tumour, cognitive disabilities, etc.*

Diagnosis: ____________________ ***If functional limitations are related to diagnosis, complete section 8.***

Epilepsy: ☐ Yes ☐ No ▸ If yes, date of first seizure: ______ Date of last seizure: ______

Non-epileptic convulsive seizures: ☐ Yes ☐ No ▸ If yes, cause: ____________ Date of last seizure: ______

Description of seizures: ____________________

Dizziness: ☐ Yes ☐ No If yes, length of episodes: ____________ **Disabling?** ☐ Yes ☐ No

Check box if there is no health disorder to report in this section ☐

Please indicate below the name, birthdate and driver's licence number (if known) of the person undergoing the medical examination.

Last name

First name

Date of birth

Driver's licence number

HEART AND VASCULAR DISORDERS

4 *Angina, aneurysm > 5.5 cm, inability to tolerate exertion, etc.*

Diagnosis: ______

Functional classification according to NYHA

- ☐ I No limitation of physical activity: no symptoms during daily activities.
- ☐ II Slight limitation of physical activity: comfortable at rest or during light physical activity.
- ☐ III Marked limitation of physical activity: comfortable only at rest.
- ☐ IV Must be at complete rest, confined to bed or chair: any type of physical activity causes discomfort and symptoms can occur even at rest.

Angina: ☐ Yes ☐ No

Arrhythmia: ☐ Yes ☐ No ▸ If yes, date and diagnosis: ______

Defibrillator: ☐ Yes ☐ No ▸ If yes, ______ date of implant ______ date of last shock ______ last equipment inspection

Loss of consciousness ▸ Date: ______ ▸ Cause: ______

Treated successfully? ☐ Yes ☐ No ▸ Specify treatment: ______

High blood pressure: ☐ Yes ☐ No ▸ If yes, indicate normal blood pressure: ______ / ______ Syst. Diast.

Aortic aneurysm (non-surgical treatment)

- ☐ Abdominal Diameter: ______ cm — **Surgically indicated** ☐ Yes ☐ No
- ☐ Thoracic Diameter: ______ cm — ☐ Yes ☐ No

Date of last exam: ______ Specify: ☐ Ultrasound ☐ CAT

If professional driver: **Heart failure:** ☐ Yes ☐ No ▸ If yes, ejection fraction: ______ %

Check box if there is no health disorder to report in this section ☐

RESPIRATORY DISORDERS

5 *Severe asthma, oxygenotherapy, sleep apnea, etc.*

Diagnosis: ______

Functional category

- ☐ I Presence or absence of shortness of breath. If short of breath, it is attributable to non-respiratory causes.
- ☐ II Shortness of breath when walking rapidly on flat terrain or when climbing a slope.
- ☐ III Shortness of breath when walking on flat terrain compared to an individual the same age or when climbing stairs.
- ☐ IV Shortness of breath after walking 100 metres at own pace on flat terrain.
- ☐ V Shortness of breath when dressing, when undressing or when speaking.

Oxygenotherapy: ☐ Yes ☐ No ▸ If yes, ☐ Nighttime ☐ Daytime Number of hours of use per day: ______

Sleep apnea: ☐ Yes ☐ No ▸ If yes, treatment effective? ☐ Yes ☐ No

Excessive daytime sleepiness: ☐ Yes ☐ No ▸ If yes, provide Epworth Score (if available): ______

Check box if there is no health disorder to report in this section ☐

DIABETES AND METABOLIC DISORDERS

6 *Poorly controlled diabetes, hypoglycemia, Grave's disease, Addison's disease, thyroid problems*

Diagnosis: ______

If diabetes is present, does the individual have a proper understanding and control of the disease? ☐ Yes ☐ No

Treatment: ☐ Insulin ☐ Hypoglycemic ☐ Diet

Symptomatic episodes of hypoglycemia requiring the action of a third party over the last 6 months. ☐ Yes ☐ No

If yes, how many? ______ Date of last episode: ______

Check box if there is no health disorder to report in this section ☐

Please indicate below the name, birthdate and driver's licence number (if known) of the person undergoing the medical examination.

Last name

First name

Date of birth

Driver's licence number

PSYCHIATRIC DISORDERS AND SUBSTANCE ABUSE

7 *Aggressiveness, behaviour disorder, personality disorder, psychosis, depression, anxiety, abuse or dependence (alcohol, drugs or medication), improper use (alcohol, alcohol + cannabis, medication, drugs), etc.*

Diagnosis according to DSM-IV: ______

Global assessment of functioning (GAF) scale according to DSM-IV: ______

Date of last psychotic episode: ______ ► Number of episodes in last year: ______ ► Number of episodes over last 3 years: ______

Based on DSM-IV: Chronic substance abuse: ☐ Yes ☐ No ► If yes, which substance? ______

Substance dependence: ☐ Yes ☐ No ► If yes, which substance? ______

Date remission began: ______

Substance use (amount, how frequently, since when): ______

Check box if there is no health disorder to report in this section ☐

FUNCTIONAL LIMITATIONS

8 *Physical limitations, amputation, congenital deformity, etc.*

Diagnosis: ______

Are this individual's movements limited? ☐ Yes ☐ No ► If yes, describe the limitations: ______

Does this individual wear a prosthesis or an orthosis? ☐ Yes ☐ No ► If yes, specify: ______

Have you noticed a change over the past 12 months:

– in physical functioning? ☐ Yes ☐ No ► If yes, specify: ______

– in cognitive functioning? ☐ Yes ☐ No ► If yes, specify: ______

Check box if there is no health disorder to report in this section ☐

CURRENT MEDICATION

9 *Side effects of medication, interaction of medication, polypharmacy, etc.*

List medication that is used regularly and specify dosage. If convenient, attach a list instead of completing this section.

NAME OF ℞	DOSAGE	FREQUENCY	NAME OF ℞	DOSAGE	FREQUENCY
		Die-Bid-Tid-Qid-prn			Die-Bid-Tid-Qid-prn
		Die-Bid-Tid-Qid-prn			Die-Bid-Tid-Qid-prn
		Die-Bid-Tid-Qid-prn			Die-Bid-Tid-Qid-prn

When the individual takes medication, does he/she experience side effecfs that affect his/her ability to safely operate a motor vehicle?

☐ Yes ☐ No ► If yes, what are they? ______

Check box if individual uses no medication on a regular basis ☐

Please indicate below the name, birthdate and driver's licence number (if known) of the person undergoing the medical examination.

Last name

First name

Date of birth

Driver's licence number

OTHER DIAGNOSES

10 *Reduced GAF, HA/ADL difficulties, deterioration of general health, morbid obesity, dialysis/kidney failure, etc.*

Diagnosis:

Diagnosis:

Diagnosis:

RECOMMENDATIONS

11 **In your opinion, should the Société require this individual to submit to additional assessments?** ☐ Yes ☐ No

▶ If yes, what type?
- On-road assessment by the Société: ☐ Yes ☐ No ▶ If yes, specify in section 12.
- Functional assessment by occupational therapist: ☐ Yes ☐ No ▶ If yes, specify in section 12.
- Specialized consultations: ☐ Yes ☐ No ▶ If yes, which specialities?

Should this individual cease driving while awaiting these assessments? ☐ Yes ☐ No ▶ If yes, specify in section 12.

ADDITIONAL COMMENTS

12 *Describe the situations that suggest risk when driving a road vehicle.*

PHYSICIAN INFORMATION

13

☐ I have been this individual's attending physician for ________ years. Number of consultations each year: ________

☐ I am not this individual's attending physician. His/her physician is: ________

☐ This individual does not have an attending physician ________

Name and address of physician (in block letters)	Signature		
	Date of examination	Date of report	Professional licence number
	Telephone	Fax	

Attach any documents you feel are relevant to the case

Protection of Personal Information

All information gathered by authorized Société de l'assurance automobile du Québec personnel is handled confidentially. The Société requires this person information to apply the *Automobile Insurance Act* and the *Highway Safety Code*. Under the *Act respecting access to documents held by public bodies and t Protection of personal information*, it may be conveyed to Government departments or agencies, or used for statistical, survey, study, audit or investigative purpose Failure to provide information can result in a refusal of service on the Société's part. Individuals may consult or correct any personal information concerning the held in Société records.

For more information, contact the Société's call centres or consult the Policy on Privacy on the Société Web site at: www.saaq.gouv.qc.ca.