

Avec vous,
au cœur de votre sécurité

Driver's licence number

Last name		Date of birth (Year-Month-Day)	
<input type="text"/>		<input type="text"/>	
First name		Telephone (home)	
<input type="text"/>		<input type="text"/>	
Address (street number, street name, apartment)		Telephone (work)	Extension
<input type="text"/>		<input type="text"/>	<input type="text"/>
Municipality	Postal code		
<input type="text"/>	<input type="text"/>		

Any fees related to this report **must be paid by the person undergoing the examination** and do not qualify for reimbursement by the SAAQ.**Return the form to:**Service de l'évaluation médicale
et du suivi du comportement
Société de l'assurance automobile du Québec
Case postale 19500, succursale Terminus
Québec (Québec) G1K 8J5**TO THE PERSON UNDERGOING THE EXAMINATION**

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

I hereby authorize the Société de l'assurance automobile du Québec to discuss, when necessary, medical information concerning me with the health care professional who has signed this form. I understand that a summary of all communications will be kept in my file.

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

Signature of the person undergoing the examination

Date (Year-Month-Day)

TO THE HEALTH CARE PROFESSIONALThe examination must take into account prior and current ailments that may affect the individual's ability to drive. **When reporting a health issue, be sure to check all the boxes that apply. Discuss any ailments that are not mentioned below in section 13.**

In the following sections, check the "NO" box if there are no health issues to report

		NO
1 VISUAL DISORDERS		NO
Visual acuity based on the Snellen Chart: Without correction: OU 6/ <input type="text"/> <input type="text"/> With correction: OU 6/ <input type="text"/> <input type="text"/>		<input type="checkbox"/> PROCEED TO THE NEXT SECTION
<input type="checkbox"/> Bilateral cataracts <input type="checkbox"/> Pseudophakia <input type="checkbox"/> AMD <input type="checkbox"/> Glaucoma <input type="checkbox"/> Retinopathy		
<input type="checkbox"/> Defect detected during confrontation visual field testing <input type="checkbox"/> Diplopia within the central 40 degrees		
2 HEARING DISORDERS		NO
<input type="checkbox"/> Presence of a hearing disorder that requires or would require the use of a hearing aid Is the person able to understand a sentence uttered in a forced whisper at a distance of 1.5 metres? <input type="checkbox"/> Yes <input type="checkbox"/> No ► If so, check the appropriate box or boxes: <input type="checkbox"/> With a hearing aid <input type="checkbox"/> Without a hearing aid		<input type="checkbox"/> PROCEED TO THE NEXT SECTION
3 NEUROLOGICAL DISORDERS		NO
Presence of a neurological disorder (if there are functional limitations related to the diagnosis, complete Section 10) <input type="checkbox"/> CVA <input type="checkbox"/> Parkinson's <input type="checkbox"/> MS <input type="checkbox"/> Head trauma <input type="checkbox"/> Brain tumour <input type="checkbox"/> Other		<input type="checkbox"/> PROCEED TO THE NEXT SECTION
Current symptoms: <input type="text"/> <input type="text"/>		
Date of diagnosis <input type="text"/> (Year-Month-Day)		



In the following sections, check the "NO" box if there are no health issues to report. ▼

4 EPILEPSY OR NON-EPILEPTIC CONVULSIVE SEIZURES				NO
<input type="checkbox"/>	Epilepsy ▶ Type of seizure	Date of the first seizure (Year-Month-Day)	Date of the last seizure (Year-Month-Day)	<input type="checkbox"/> PROCEED TO THE NEXT SECTION
	Generalized, focal impaired awareness (complex partial) and absence			
	Nocturnal			
	Focal aware (simple partial)			
<input type="checkbox"/>	Non-epileptic convulsive seizures Cause: _____ Date of the last seizure: _____ (Year-Month-Day) Describe how the seizures manifest: _____ _____ _____ _____			
5 HEART AND VASCULAR DISORDERS				NO
<input type="checkbox"/>	Presence of a heart disorder that severely limits physical activity Functional class ▶ <input type="checkbox"/> III Marked limitation of physical activity: comfortable only at rest ▶ <input type="checkbox"/> IV Must be at complete rest, confined to bed or a chair: any type of physical activity causes discomfort and symptoms can occur even at rest			<input type="checkbox"/> PROCEED TO THE NEXT SECTION
<input type="checkbox"/>	Arrhythmia ▶ Diagnosis: _____ Date of diagnosis: _____ (Year-Month-Day)			
<input type="checkbox"/>	Defibrillator ▶ Date of implant: _____ Date of the last shock: _____ (Year-Month-Day) (Year-Month-Day)			
<input type="checkbox"/>	Aortic aneurysm requiring surgery Diameter: _____ cm			
<input type="checkbox"/>	Syncopes in the last 12 months Number of episodes: _____ Date of the last episode: _____ (Year-Month-Day) Cause: _____ Treated successfully? <input type="checkbox"/> Yes <input type="checkbox"/> No Specify treatment: _____			
If a professional driver (Classes 1, 2, 3, 4A, 4B): <input type="checkbox"/> Heart failure ▶ Provide the ejection fraction: _____ %				
6 RESPIRATORY DISORDERS				NO
<input type="checkbox"/>	Presence of a respiratory disease that limits activities Functional category: <input type="checkbox"/> III Shortness of breath when walking on flat terrain compared to an individual the same age or when climbing stairs <input type="checkbox"/> IV Shortness of breath after walking 100 metres at his or her own pace on flat terrain <input type="checkbox"/> V Shortness of breath when dressing, when undressing or when speaking			<input type="checkbox"/> PROCEED TO THE NEXT SECTION
<input type="checkbox"/>	Oxygenotherapy ▶ <input type="checkbox"/> Nighttime <input type="checkbox"/> Daytime ▶ Number of hours of use per day: _____			
<input type="checkbox"/>	Sleep apnea ▶ Treatment effective? <input type="checkbox"/> Yes <input type="checkbox"/> No ▶ Excessive daytime sleepiness? <input type="checkbox"/> Yes <input type="checkbox"/> No ▶ If so, provide the apnea-hypopnea index: _____			



In the following sections, check the "NO" box if there are no health issues to report.

7	DIABETES	NO
<p>Does the person have a proper understanding and control of his or her diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No ▶ Treatment: <input type="checkbox"/> Insulin <input type="checkbox"/> Hypoglycemic agent</p> <p>In the last six months, has the person had hypoglycemic episodes while awake that resulted in an alteration of consciousness and required the intervention of a third party? <input type="checkbox"/> Yes <input type="checkbox"/> No ▶ How many? _____ Date of the last episode: _____ (Year-Month-Day)</p> <p>If a professional driver (Classes 1, 2, 3, 4A, 4B): Glycated hemoglobin (HbA1c): _____ %</p>		<input type="checkbox"/> PROCEED TO THE NEXT SECTION
8	PSYCHIATRIC DISORDERS	NO
<p><input type="checkbox"/> Presence of uncontrolled psychiatric disorders that present a risk when driving a road vehicle Diagnosis: _____</p> <p>Does the person have the necessary sense of self-criticism and judgment for driving? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Current symptoms: _____</p> <p>Number of psychotic episodes or episodes of acute mania in the last 12 months: <input type="checkbox"/> 1 <input type="checkbox"/> 2 or more Date of the last psychotic episode: _____ (Year-Month-Day)</p> <p><input type="checkbox"/> The person is unfit to safely drive professional classes of vehicle (Class 1, 2, 3, 4A, 4B) ▶ Specify: _____</p>		<input type="checkbox"/> PROCEED TO THE NEXT SECTION
9	SUBSTANCE USE DISORDERS	NO
<p><input type="checkbox"/> Presence of a substance use disorder (based on the DSM-5)</p> <p>Type of substances: <input type="checkbox"/> Alcohol <input type="checkbox"/> Drugs <input type="checkbox"/> Other ▶ _____</p> <p>Severity: <input type="checkbox"/> Mild (2-3 criteria) <input type="checkbox"/> Moderate (4-5 criteria) <input type="checkbox"/> Severe (6 criteria or more)</p> <p>Remission start date: _____ (Year-Month-Day)</p> <p>Specify the person's consumption habits (frequency and amount consumed/day): ▶ Before remission: _____ ▶ After remission: _____</p>		<input type="checkbox"/> PROCEED TO THE NEXT SECTION
10	FUNCTIONAL LIMITATIONS	NO
<p><input type="checkbox"/> Presence of a functional limitation that could present a risk when driving, or have an effect on driving</p> <p><input type="checkbox"/> Physical limitation ▶ Describe the impairment: _____</p> <p><input type="checkbox"/> Cognitive limitation ▶ Describe the impairment: _____</p> <p>Limitations to instrumental activities of daily living/activities of daily living ▶ Specify: _____</p> <p><input type="checkbox"/> Diagnosis of dementia ▶ Causes: _____ ▶ Severity: _____</p> <p>Have you noticed a change over the past 12 months:</p> <p>– in physical functioning? <input type="checkbox"/> Yes <input type="checkbox"/> No ▶ Specify: _____</p> <p>– in cognitive functioning? <input type="checkbox"/> Yes <input type="checkbox"/> No ▶ Specify: _____</p>		<input type="checkbox"/> PROCEED TO THE NEXT SECTION



In the following sections, check the "NO" box if there are no health issues to report.

11 CURRENT MEDICATION

Use of medication of the following classes:

Class of medication	Name of Rx	Dose	Frequency
<input type="checkbox"/> Anticonvulsants			
<input type="checkbox"/> Antidepressants			
<input type="checkbox"/> Antipsychotics			
<input type="checkbox"/> Anxiolytics/Sleep aids			
<input type="checkbox"/> Opioids/Narcotics			
<input type="checkbox"/> Other (enclose a list)			

When taking this medication, does the person experience side effects that affect his or her ability to drive safely (decrease in vigilance or psychomotor retardation, drug interactions, polypharmacy, etc.)?

☐ Yes ☐ No

Describe the side effects and their severity:

NO

☐
PROCEED
TO THE
NEXT
SECTION

12 RECOMMENDATIONS

Do you believe the SAAQ should require the person to submit to additional assessments regarding his or her fitness to drive?

– Road test by an SAAQ examiner:

☐ Yes ☐ No

– Functional assessment by an occupational therapist:

☐ Yes ☐ No

– Specialized consultations: ☐ Yes ☐ No

► If so, specify the specialties: _____

Should the person cease driving while awaiting these assessments?

☐ Yes ☐ No

13 DESCRIBE ANY SITUATIONS OR DIAGNOSES THAT MAY PRESENT A RISK TO DRIVING A ROAD VEHICLE

INFORMATION REGARDING THE HEALTH CARE PROFESSIONAL

☐ This person has been under my care since: _____ ► Number of consultations per year: _____

☐ OR This person has been under the care of: _____

Last name and first name (please print)	Profession	Professional licence number	
Address (street number, street name, apartment)	Postal code	Telephone (work)	Extension
Municipality	Signature	Date of report (Y-M-D)	

Attach any documents you feel are relevant to the case.

Protection of Personal Information

All personal information gathered by authorized Société de l'assurance automobile du Québec (SAAQ) personnel is handled confidentially. The SAAQ requires this information to apply the laws it is responsible for administering, in particular the *Highway Safety Code*, the *Automobile Insurance Act* and the *Act respecting remunerated passenger transportation by automobile*. Under the *Act respecting Access to documents held by public bodies and the Protection of personal information*, this information may be conveyed to the SAAQ's licensing agents and other Government departments or agencies, or used for statistical, survey, study, audit or investigative purposes. Failure to provide this information can result in a refusal of service. You may consult, correct or obtain a copy of any personal information concerning you.

For more information, consult the Policy on Privacy on the SAAQ's website at saaq.gouv.qc.ca or contact the SAAQ's call centre.