ADDING A CLASS

Société de l'assurance automobile Québec

Avec vous, au cœur de votre sécurité

Report on a Person's State of Health – Driver's Licence

28

Driver's licence number

Last name

Date of birth (Year-Month-Day)

First name

Telephone (home)

Address (street number, street name, apartment)

Telephone (work)

Extension

Municipality

Postal code

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 PROFESSIONAL

The 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

1 VISUAL DISORDERS

NO ☐ PROCEED TO THE NEXT SECTION

Visual acuity based on the Snellen Chart: Without correction: OU 6/ ___ With correction: OU 6/ ___

☐ Bilateral cataracts ☐ Pseudophakia ☐ AMD ☐ Glaucoma ☐ Retinopathy

☐ **Defect detected during confrontation visual field testing** ☐ **Diplopia within the central 40 degrees**

2 HEARING DISORDERS

NO ☐ PROCEED TO THE NEXT SECTION

☐ **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?

☐ Yes ☐ No ▶ **If so**, check the appropriate box or boxes: ☐ **With a hearing aid** ☐ **Without a hearing aid**

3 NEUROLOGICAL DISORDERS

NO ☐ PROCEED TO THE NEXT SECTION

Presence of a neurological disorder *(if there are functional limitations related to the diagnosis, complete Section 10)*

☐ CVA ☐ Parkinson's ☐ MS ☐ Head trauma ☐ Brain tumour ☐ Other

Current symptoms:

Date of diagnosis (Year-Month-Day)

Driver's licence number

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

4 EPILEPSY OR NON-EPILEPTIC CONVULSIVE SEIZURES

NO ☐ PROCEED TO THE NEXT SECTION

☐ **Epilepsy**

Type of seizure	Date of the first seizure (Year-Month-Day)	Date of the last seizure (Year-Month-Day)
Generalized, focal impaired awareness (complex partial) and absence		
Nocturnal		
Focal aware (simple partial)		

☐ **Non-epileptic convulsive seizures**

Cause: ______ Date of the last seizure: ______ (Year-Month-Day)

Describe how the seizures manifest:

______

5 HEART AND VASCULAR DISORDERS

NO ☐ PROCEED TO THE NEXT SECTION

☐ **Presence of a heart disorder that severely limits physical activity**

Functional class
- ☐ III Marked limitation of physical activity: comfortable only at rest
- ☐ 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

☐ **Arrhythmia** Diagnosis: ______ Date of diagnosis: ______ (Year-Month-Day)

☐ **Defibrillator** Date of implant: ______ (Year-Month-Day) Date of the last shock: ______ (Year-Month-Day)

☐ **Aortic aneurysm requiring surgery** Diameter: ______ cm

☐ **Syncopes in the last 12 months** Number of episodes: ______ Date of the last episode: ______ (Year-Month-Day)

Cause: ______ Treated successfully? ☐ Yes ☐ No

Specify treatment: ______

If a professional driver (Classes 1, 2, 3, 4A, 4B): ☐ Heart failure Provide the ejection fraction: ______ %

6 RESPIRATORY DISORDERS

NO ☐ PROCEED TO THE NEXT SECTION

☐ **Presence of a respiratory disease that limits activities**

Functional category:
- ☐ 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 his or her own pace on flat terrain
- ☐ V Shortness of breath when dressing, when undressing or when speaking

☐ **Oxygenotherapy** ☐ Nighttime ☐ Daytime Number of hours of use per day: ______

☐ **Sleep apnea** Treatment effective? ☐ Yes ☐ No

Excessive daytime sleepiness? ☐ Yes ☐ No **If so**, provide the apnea-hypopnea index: ______

Driver's licence number

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

7 DIABETES

NO ☐ PROCEED TO THE NEXT SECTION

Does the person have a proper understanding and control of his or her diabetes? ☐ Yes ☐ No ▶ Treatment: ☐ Insulin ☐ Hypoglycemic agent

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? ☐ Yes ☐ No ▶ How many? ______ Date of the last episode: ______ (Year-Month-Day)

If a professional driver (Classes 1, 2, 3, 4A, 4B): Glycated hemoglobin (HbA1c): ______ %

8 PSYCHIATRIC DISORDERS

NO ☐ PROCEED TO THE NEXT SECTION

☐ **Presence of uncontrolled psychiatric disorders that present a risk when driving a road vehicle**

Diagnosis: ______

Does the person have the necessary sense of self-criticism and judgment for driving? ☐ Yes ☐ No

Current symptoms: ______

Number of psychotic episodes or episodes of acute mania in the last 12 months: ☐ 1 ☐ 2 or more Date of the last psychotic episode: ______ (Year-Month-Day)

☐ **The person is unfit to safely drive professional classes of vehicle (Class 1, 2, 3, 4A, 4B)** ▶ Specify: ______

9 SUBSTANCE USE DISORDERS

NO ☐ PROCEED TO THE NEXT SECTION

☐ **Presence of a substance use disorder (based on the *DSM-5*)**

Type of substances: ☐ Alcohol ☐ Drugs ☐ Other ▶ ______

Severity: ☐ Mild (2-3 criteria) ☐ Moderate (4-5 criteria) ☐ Severe (6 criteria or more)

Remission start date: ______ (Year-Month-Day)

Specify the person's consumption habits (frequency and amount consumed/day):
▶ Before remission: ______
▶ After remission: ______

10 FUNCTIONAL LIMITATIONS

NO ☐ PROCEED TO THE NEXT SECTION

☐ **Presence of a functional limitation that could present a risk when driving, or have an effect on driving**

☐ **Physical limitation** ▶ Describe the impairment: ______

☐ **Cognitive limitation** ▶ Describe the impairment: ______

Limitations to instrumental activities of daily living/activities of daily living ▶ Specify: ______

☐ **Diagnosis of dementia** ▶ Causes: ______
▶ Severity: ______

Have you noticed a change over the past 12 months:

– in physical functioning? ☐ Yes ☐ No ▶ Specify: ______

– in cognitive functioning? ☐ Yes ☐ No ▶ Specify: ______

Driver's licence number

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

11 CURRENT MEDICATION

NO ☐ PROCEED TO THE NEXT SECTION

Use of medication of the following classes:

Class of medication	Name of medication	Dose	Frequency
☐ Anticonvulsants			
☐ Antidepressants			
☐ Antipsychotics			
☐ Anxiolytics/Sleep aids			
☐ Opioids/Narcotics			
☐ 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:

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

The SAAQ only collects personal information that is necessary for it to exercise its powers and apply the laws it administers. All personal information gathered by authorized personnel is handled confidentially. This information may be shared with its licensing agents and certain government departments or agencies, including those located outside Québec, in accordance with the *Act respecting Access to documents held by public bodies and the Protection of personal information*. It may also be 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/privacy or contact the SAAQ's call centre.