Société de l'assurance automobile Québec

Avec vous, au cœur de votre sécurité

Assessment Report

Fees for the completion of this report are either paid directly to the physician or reimbursed to the accident victim up to the maximum amount authorized by the SAAQ.

Erase

Section 1 – Information on the accident victim

Last name at birth and first name

Address

Postal code

Health insurance number

Date of birth (Year Month Day)

Date of the accident (Year Month Day)

Section 2 – To be completed by the accident victim's physician or specialized nurse practitioner (SNP)

Date of the medical examination (Year Month Day)

Please print clearly.

2.1 – Medical history

Did your patient have any prior medical conditions? ☐ Yes. Please specify: ☐ No ▸ **(If no, go to section 2.2)**

☐ Trauma-related: ☐ Surgical:

☐ Medical: ☐ Psychiatric:

Was your patient taking medication or receiving other treatment at the time of the accident? ☐ Yes ☐ No

If so, please specify:

Describe prior functional limitations, if any:

Did these prior limitations already render your patient permanently unfit to hold employment? ☐ Yes ☐ No ☐ Do not know

2.2 – Background and clinical examination

Describe the physical and/or psychological symptoms reported by your patient:

Describe the clinical signs noted during the physical and/or psychological examination:

2.3 – Tests

Are any results consistent with the objective clinical signs noted during the physical examination? ☐ Yes. Please specify: ☐ No ▸ **(If no, go to section 2.4)**

Medical imaging: ☐ Copy of the report enclosed

Other: ☐ Copy of the report(s) enclosed

Are additional tests requested or expected? ☐ Yes ☐ No

If so, please specify: Anticipated date: ▸ (Year Month Day)

Have one or more medical consultations taken place? ☐ Yes ☐ No

Physician consulted:

Specialty: ☐ Copy of the report enclosed

Physician consulted:

Specialty: ☐ Copy of the report enclosed

Claim No.

Communication No.

RV

2.4 – Diagnosis

Describe the injuries or diagnoses related to the accident:

2.5 – Treatment

Is treatment currently required for injuries sustained in the accident? ☐ Yes. Please specify: ☐ No ▸ **(If no, go to section 2.6)**

☐ Medication (name):

▸ **Important:** Written justification must be provided for any medication that is not listed in the basic prescription drug insurance plan.

☐ Surgery: Performed or scheduled on: Year Month Day

☐ Physiotherapy ☐ Occupational therapy ☐ Chiropractic ☐ Acupuncture ☐ Psychotherapy

☐ Other:

2.6 – Functional limitations and restrictions

Describe any functional limitations or restrictions in connection with these injuries:

Mobility:

Tolerance to effort:

Postural tolerance:

Activities of daily living:

Psychological/cognitive functions:

Other:

Section 3 – Additional comments

Would you like an SAAQ representative to contact you? ☐ Yes ☐ As needed ☐ No

Information on the physician or SNP

Last name and first name (print)	**Licence number**	☐ General practitioner ☐ SNP ☐ Specialist, specify:
Address (street number, street name, apartment)	Municipality	Postal code
Telephone / Extension	Fax	Email
Signature (do not use stamp)		Date Year Month Day

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/confidentialite or contact the SAAQ's call centre.

THERE ARE THREE WAYS TO SUBMIT A DOCUMENT:
Through the Reimbursement of Expenses and Document Submission online service: saaq.gouv.qc.ca/envoidocuments
By fax: 1-866-289-7952
By mail: Société de l'assurance automobile du Québec
Case postale 2500, succursale Terminus
Québec (Québec) G1K 8A2

Keep the original or a copy for your files.

Claim No. | Communication No.

RV

Société de l'assurance automobile Québec

Avec vous,
au cœur de votre sécurité

Receipt or Invoice for a Medical Report

Section 1 – Information on the accident victim

Last name at birth and first name	Claim number	Communication No.

Section 2 – Information on the medical report

Type of report: ☒ Assessment Report (IV) ☐ Progress Report (IO) ☐ After-Effects Report (IQ)

Please fill out the appropriate section

Fees reimbursed to the accident victim by the SAAQ

Receipt

Section 3 – Receipt for the accident victim or his or her representative

Amount paid	Signature of physician (or person in charge)	Date
$		Year Month Day

OR

Fees paid to the physician by the SAAQ

Invoice

Section 4 – Information on the physician

Last name and first name (print)		Licence number
Address (street number, street name, apartment)	Municipality	Postal code
Telephone / Extension	Date (Year Month Day)	Amount claimed: $

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