Société de l'assurance automobile Québec

Avec vous, au cœur de votre sécurité

Invoice for Complementary Medical Information – Disability

Destiné seulement aux professionnels de la santé qui n'ont pas d'adresse au Québec.

Accident victim		
Name and address	Claim Number:	
	Health Insurance Number:	
	Date of accident (Y-M-D):	

Attending physician		
Name and address		

Doctor,

In your recent medical reports, you indicate that your patient is currently unable to return to work.

In order to assess the overall situation, properly compensate your patient and evaluate the possibility of a referral for rehabilitation, we ask you to fill out the questionnaire intended to provide the additional medical information we require.

For your information, if your patient was not employed at the time of the accident, the SAAQ determines an occupation based on his or her training and work experience which he or she could have held were it not for the accident. The disability must be appraised based on the requirements of this occupation. A job description for this employment is enclosed.

Thank you in advance for your cooperation and attention to our request.

Compensation Officer	Signature	Date (Y-M-D)

Fee Invoicing		
The following fee will be paid on receipt of your completed questionnaire.		
Name of physician	Licence Number	Professional fees
Signature of attending physician	Date (Y-M-D)	

THERE ARE THREE WAYS TO SUBMIT A DOCUMENT:

Through the following French-language online service: Envoi de documents et Remboursement de frais pour les intervenants externes: saaq.gouv.qc.ca/services-en-ligne/intervenants-externes
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.

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Claim Number

Please take note of the demands and constraints of the employment. (see description enclosed)

1. Specify the limitations and/or functional restrictions **resulting from the injuries sustained in the accident**, and indicate whether they are temporary or permanent. (On page 3 is a chart listing the functional restrictions usually encountered. You can use this chart to specify the functional restrictions).

2. If you consider your patient still temporary unable to resume the specified employment, detail your treatment plan and the projected date of the end of the disability period. Please mention on this report if you believe your patient is able to return to work.

3. If you believe that your patient could encounter difficulties with a reintegration in his or her work environment, please specify them (e.g. gradual return to work, light duties, bio-psychosocial factors, etc.).

4. If you believe that your patient will be permanently unable to perform the specified employment, indicate this information and detail the reasons.

Would you like an assessing physician at the SAAQ to contact you by telephone? ☐ Yes ☐ No

Please list your availabilities:

Physician			
Name of the physician	Discipline		
Licence Number	Telephone		Extension
Attending physician's signature		Date (Y-M-D)	

Protection of Personal Information
All information gathered by the SAAQ for the purposes of administering the public automobile insurance plan is handled confidentially. The SAAQ will only use or disclose such information for purposes prescribed by law. The SAAQ's Policy on Privacy is available at saaq.gouv.qc.ca/en/policies/policy-on-privacy/.

N.B.: Should you wish to discuss the matter with the compensation officer assigned to the claim or the assessing physician at the SAAQ, simply call this telephone number reserved for your use: 1-866-599-6915.

Claim Number

IDENTIFICATION OF FUNCTIONAL RESTRICTIONS

The chart below is a guide. You can indicate the functional restrictions that apply **in connection with injuries sustained in the accident** either in the space reserved for this purpose on page 2 or by completing the chart below. Specify if the restrictions are deemed temporary or permanent.

		Avoid activities that require the following:	Prognosis: Temporary / projected duration	Prognosis: Permanent
Physical Abilities	Strength	Performing activities that require the patient to repeatedly and frequently lift, carry, push or pull objects weighing: ☐ under 5 kg ☐ 5 to 9 kg ☐ 10 to 19 kg ☐ 20 kg or over		
	Body Position	Climbing (ladders, stairs, scaffolding, etc.) Specifics:		
		Working in uncomfortable positions (crouching, kneeling, stooping, crawling) Specifics:		
		Walking on uneven or slippery surfaces		
		Walking for long periods Maximum period:		
		Remaining in one position for long periods ☐ Sitting Maximum period: _____ ☐ Standing Maximum period: _____ Sustaining a joint position _____ Maximum period: _____ Additional information: (e.g. need to alternate positions, frequency, etc.)		
		To repeatedly and frequently perform the following movements: (specify the movement(s) and the joint in question) _____ ☐ with extreme ranges of motion ☐ small ranges of motion beyond _____ °		
	Manual Dexterity	Manual dexterity (handle, grasp objects with fingertips, perform precision work, carry out rapid finger movements, etc.) Specifics:		
Other		Where applicable, specify risks to avoid in the workplace:		
		Specify: (e.g. vision – sensory perception, physical endurance, etc.)		