Société de l'assurance automobile Québec

Avec vous, au cœur de votre sécurité

Progress 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 examination (Year / Month / Day)

Please print clearly.

2.1 – Medical history and clinical examination

Describe the physical and/or psychological symptoms reported by your patient (if applicable, specify the date on which new symptoms appeared):

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

2.2 – Additional tests

Were tests performed? ☐ Yes. Specify and enclose a copy of the report: ☐ No

Are additional tests requested or expected? ☐ Yes. Specify: ☐ No

Has a consultation with a specialist taken place? ☐ Yes. Indicate the specialist physician's name and specialty and enclose the report: ☐ No

2.3 – Diagnosis

Describe the injuries related to the accident or their complications:

For any psychological injuries, use the DSM multiaxial diagnostic system.

Axis 1: _____

Axis 2: _____

Axis 3: _____

Axis 4: _____

Axis 5: GAF (current): _____ Usual GAF (before the accident): _____

Claim No.

Communication No.

RO

2.4 – Treatment

Is treatment still required? ☐ Yes. Please specify: ☐ No ▸ **(If no, go to section 2.5)**

☐ 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: _____

2.5 – Progress and prognosis

The progress of your patient's functional impairment is considered:

☐ Positive ▸ The functional impairments will end on: Year Month Day or will be extended by _____ weeks.

☐ Stable ▸ As of: Year Month Day

☐ Negative ▸ Specify: _____

Has a new event unrelated to the accident occurred? ☐ Yes. Please specify: ☐ No

_____ If Yes, enter the date: Year Month Day

Did this result in a change in your patient's condition? ☐ Yes. Please explain: ☐ No

_____

_____

2.6 – Functional limitations and restrictions

Describe any persistent functional limitations and/or restrictions in connection with your patient's injuries:

	Are they permanent? Yes	No	Cannot say
Mobility: _____	☐	☐	☐
Tolerance to effort: _____	☐	☐	☐
Postural tolerance: _____	☐	☐	☐
Activities of daily living: _____	☐	☐	☐
Psychological/cognitive: _____	☐	☐	☐
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

RO

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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