Erase

Société de l'assurance automobile Québec

Avec vous, au cœur de votre sécurité

Medical Examination Report on a Diabetic Person's Fitness to Safely Operate a Motor Vehicle

90

Driver's licence number: _____

Licence holder

Last name

First name

Date of birth (Year-Month-Day)

Address

Street number | Street name | Apartment

Municipality | Postal code | Telephone (main)

Any fees charged for completing this form **must be paid by the examinee** and do not qualify for reimbursement by the SAAQ.

Submit this form through your SAAQclic account: saaqclic.saaq.gouv.qc.ca/en

Or

Return it by mail to:
Direction de l'accompagnement
et de l'expertise santé
Société de l'assurance automobile du Québec
Case postale 19500, succursale Terminus
Québec (Québec) G1K 8J5

For the examinee

Please read and sign the authorization below and read the statement regarding the protection of personal information at the bottom of page 3.

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 _____ Date (Year-Month-Day) _____

For the health care professional

The examination must take into account prior and current ailments that may affect the person's ability to drive.

Discuss any positive response under "Recommendations and comments" in section 5.

1 Background information

Date of diabetes diagnosis (Year-Month-Day): _____ **Diabetes:** ▸ Type I: _____ ▸ Type II: _____

Has the person been adequately informed about diabetes? ☐ Yes ☐ No

Explain: _____

Was the person hospitalized during the past 2 years for a diabetes-related condition? ☐ Yes ☐ No

Number of times: _____ ▸ Dates (Year-Month-Day): _____ ▸ _____ ▸ _____ ▸ _____

Explain: _____

Glycohemoglobin levels (HbA1c) – (normal laboratory value): _____

Give the test dates and results for the past 12 months. One of these tests must have been carried out every 6 months over a period of 12 months.

▸ Date (Year-Month-Day): _____ Result: _____ ▸ Date (Year-Month-Day): _____ Result: _____

▸ Date (Year-Month-Day): _____ Result: _____ ▸ Date (Year-Month-Day): _____ Result: _____

Driver's licence number: _____

1 Background information (continued)

Average number of times the blood glycemic levels are measured per day: _____

Does this person know that he or she must stop driving as soon as his or her glycemic level is below 4 mmol/L? ☐ Yes ☐ No

2 Medication

Hypoglycemic medication: _____

- Dosage: _____
- If insulin, injection schedule and types of insulin: _____

3 Hypoglycemia

Does this person recognize the symptoms of hypoglycemia when they occur? ☐ Yes ☐ No

Is this person able to treat hypoglycemia quickly? ☐ Yes ☐ No

During the past 6 months, did the person experience episodes of hypoglycemia:

- Requiring hospitalization? ☐ Yes ☐ No
- Requiring a trip to an emergency room? ☐ Yes ☐ No
- Resulting in loss of consciousness? ☐ Yes ☐ No
- Requiring the help of another person? ☐ Yes ☐ No
- Occurring without warning? (no symptoms, or symptoms not felt) ☐ Yes ☐ No
- Reducing attention or ability to drive? ☐ Yes ☐ No

If you answered Yes to one of the preceding questions, please describe the episodes and specify dates and causes as well as any other characteristics or circumstances:

Average number of minor episodes of hypoglycemia per month (recognized and treated by the patient): _____

Driver's licence number: _____

4 Diabetes-related conditions

Previous history or current symptoms or signs of:

- Cardiovascular diseases: ☐ Yes ☐ No
- Ocular diseases: ☐ Yes ☐ No
- Neurological problems: ☐ Yes ☐ No
- Renal deficiency: ☐ Yes ☐ No

If you answered Yes to any of the above, specify the diagnosis and current symptoms: _____

Loss of sensitivity in lower limbs:

Right	None	Slight	Significant	**Left**	None	Slight	Significant
Touch:	☐	☐	☐	Touch:	☐	☐	☐
Pain:	☐	☐	☐	Pain:	☐	☐	☐
Vibration:	☐	☐	☐	Vibration:	☐	☐	☐

5 Recommendations and comments

In your opinion, does this person comply with medical recommendations? ☐ Yes ☐ No **If not,** please specify:

Comments:

Attach a separate sheet if needed.

Examining health care professional

The patient has been in my care since (Year-Month-Day): _____ Number of visits per year: _____

Last name and first name (please print)	Profession	Professional licence number

Address	Street number	Street name	Apartment	Municipality	Postal code

Telephone (work)	Extension	Fax	Examination date (Year-Month-Day)	Date of the report (Year-Month-Day)	**Signature**

You may enclose with this form any document you deem relevant.

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.

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