Société de l'assurance automobile Québec

Avec vous, au cœur de votre sécurité

Medical Cardiovascular Examination Report

11

Driver's Licence

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 2.

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 "Comments" in section 3.

1 Medical history and present condition

Aneurysm: ☐ **of the abdominal aorta** ☐ **of the thoracic aorta**

- Is surgery indicated? ☐ Yes ☐ No
- Diameter of aneurysm: _____ cm
- Last examination (Year-Month-Day): _____
- Surgery performed on (Year-Month-Day): _____

☐ Conventional surgery ☐ Stent

Coronary cardiopathy (current or prior): ☐ Yes ☐ No

- **If so,** since when (Year-Month-Day)? _____
- Diagnosis: _____

Angina: ☐ Yes ☐ No

Coronary surgery or transluminal angioplasty:

☐ Yes ☐ No ▸ Date (Year-Month-Day): _____

Arrhythmia: ☐ Yes ☐ No

- Diagnosis: _____
- Under control: ☐ Yes ☐ No
  - **If so,** since when (Year-Month-Day)? _____
- If applicable, please specify the medical device used:

☐ Defibrillator ☐ Pacemaker

- Date of implant (Year-Month-Day): _____
- Date of last shock (Year-Month-Day): _____
- Date of last equipment inspection (Year-Month-Day): _____

Heart failure: ☐ Yes ☐ No

- **Ejection fraction (LVEF):** _____ %
- Examination date (Year-Month-Day): _____

Driver's licence number: _____

1 Medical history and present condition (continued)

Syncopes: ☐ Yes ☐ No

- Number of episodes in last 12 months: _____
- Last episode (Year-Month-Day): _____
- Cause: _____
- Treated successfully? ☐ Yes ☐ No
- Specify treatment: _____

Other cardiac (endo-, myo-, pericarditis, congenital cardiopathy, valvular disorder, valvular replacement, etc.):

☐ Yes ☐ No ▸ **If so,** please specify:

_____

_____

_____

_____

_____

2 Functional class

In all cases, please check the functional classification according to NYHA:

☐ I – No limitation of physical activity: no symptoms during daily activities.

☐ II – Slight limitation of physical activity: comfortable at rest or during light physical activity.

☐ III – Marked limitation of physical activity: comfortable only at rest.

☐ IV – Must be at complete rest, confined to bed or chair: any type of physical activity causes discomfort and symptoms can occur even at rest.

3 Comments

Please specify the diagnosis, relevant dates, medication, treatment and result, describe functional state, complications, frequency and severity of syncopes, attendant conditions, compliance with treatment, etc.

_____

_____

_____

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_____

_____

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.

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.