

Commercial Driver's Licence Medical Report



Physicians can not be billed SGI for this report. Payment is the driver's responsibility.

Medical Review Unit - 3rd Floor
 2260 - 11th Ave., Regina, SK S4P 2N7
 Toll Free Phone Number: 1-800-667-8015 ext. 6176
 Local Phone Number: 775-6176
 Toll Free Fax: 1-866-274-4417 or 347-2577
 E-mail: mruinquires@sgi.sk.ca

Last Name _____ First _____ Middle Initial _____

Number & Street or Box Number _____

Town/City _____ Prov _____ Postal Code _____

Driver's Certificate and Waiver

I certify that the information I have given in this report, to the best of my knowledge, is correct and complete. I agree to allowing my physician to forward this report directly to the Auto Fund Division. I also understand that any driver's licence issued to me may be withdrawn if I do not meet the medical requirements for the licence.

Date: _____ Signature of Applicant: _____

Home Ph: _____ Business Ph: _____

DRIVER'S LICENCE INFORMATION

Driver's Licence Number: _____ Present Restrictions: _____ Date of Birth DD MM YYYY

Present Class of Licence: _____ Present Endorsement: _____ Male Female

Class of driver's licence for which application is made: _____

Name of Examining Physician _____ Office Telephone Number _____ Fax Number _____

Address _____ Postal Code _____ Email Address _____

PHYSICIAN TO COMPLETE (below)

A. VISION Normal

Acuities	Uncorrected	Corrected
Right	20/	20/
Left	20/	20/
Both	20/	20/

Horizontal Fields				
Right	Normal	<input type="checkbox"/>	Restricted	<input type="checkbox"/>
Left	Normal	<input type="checkbox"/>	Restricted	<input type="checkbox"/>

Any ocular condition that could affect driving?
 Yes No Describe: _____

B. THE SENSES Normal

1. Hearing Loss: Loss greater than 40 decibels averaged at 500, 1000, and 2000 Hz. (Applies only to commercial drivers.)

2. Hearing Aids: Single Bilateral

3. Vertigo: Controlled Uncontrolled

4. Menieres: Controlled Uncontrolled

C. CARDIOVASCULAR Normal

1. NYHA: Class: 1-No limitation 2-Mild 3-Moderate 4-Severe

2. CAD: Mild Moderate Severe

3. Hypertension: BP: _____ TX: _____

4. Myocardial Infarction: Date: _____ Stable Unstable

5. Angina Pectoris: Stable Unstable

6. Heart Surgery
 Angioplasty: Date: _____
 CABG: Date: _____
 Pacemaker: Date: _____
 Other: _____

7. Stress Test: Date: _____ Mets: _____

8. ICD: Insertion Date: _____ Last Discharge Date: _____

9. Arrhythmia, Sick Sinus Syndrome, etc.: _____

10. Peripheral Vascular Disease Deficits(s): _____

11. Aneurysm: Location: _____ Size: _____

12. Other: _____

Health History and Physical Examination

D. CENTRAL NERVOUS SYSTEM

Normal

1. TIA: Date: _____ Deficits: _____
2. CVA: Date: _____ Deficits: _____
3. Dementia: MMSE Score: _____ FAQ: _____
4. Head Injury: Date: _____ Deficits: _____
5. Syncope/Fainting/Blackouts: Cause: _____
6. Craniotomy: Date: _____ Reason: _____
7. Epilepsy/Seizure: Onset of Seizures: _____
Type of Seizures: _____
Frequency of Seizures: _____
Medications and Dosage: _____
Date of Last Seizure: _____
8. Progressive Disorders: Parkinson's MS ALS
Other Stable Deficits
9. Other: _____

E. RESPIRATORY

Normal

1. Sleep Disorder/Narcolepsy: Yes No
Investigation/Treatment: CPAP
2. COPD: _____
3. Oxygen: Continuous O₂ Supplementary
4. Other: _____

F. METABOLIC - ENDOCRINE

Normal

1. Diabetes Mellitus: Insulin: Yes No
2. Hypoglycemia: No Yes Date of last episode: _____
LOC 3rd Party Intervention Date: _____
3. Hg A1C Level: _____ Date: _____
4. Complications relating to Diabetes: _____
5. Other: _____

G. MUSCULOSKELETAL

Normal

1. Amputation: Which limb: _____ When: _____
2. Altered ROM: _____
3. Arthritis: No Yes Severity: _____
4. Disorder of Spine: _____
5. Other: _____

H. PSYCHIATRIC

Normal

1. Psychosis: Stable: Unstable:
Last hospitalization Date: _____
2. Severe Depression: _____
3. Treatment Compliance: Yes No
If no, please explain: _____
4. Other: _____

I. OTHER CONDITIONS

None

1. Alcohol or Drug Abuse: Yes No
2. Alcohol Related Seizures: Yes No
3. Alcohol Rehab Taken: Yes No
4. Prescribed Drugs that could impair, explain: _____
5. Physiologic changes of age (Physical and/or Mental)
i.e.: diminished response times: _____

J. OVERALL CONCLUSION:

1. Describe any other significant physical or mental impairment or condition which would likely interfere with the individual's ability to safely operate a motor vehicle.
2. Should patient's ability to drive be further assessed?
 No
 Driver Evaluation Program (Regina/Saskatoon)
 SGI Road Test

For more information regarding the above programs, please go to www.sgi.sk.ca (Drivers>Medical Conditions and Driving Privileges).

Enclose investigations/results (i.e., EEG, CT, etc.) and make comments regarding any physical or cognitive deficits related to your assessment.

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Date _____

Physician's Signature _____