

# Commercial Driver's Licence Medical Report



Physicians can not bill 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: [mruinquiries@sgi.sk.ca](mailto:mruinquiries@sgi.sk.ca)

Form can be completed by a Physician, Nurse Practitioner or Occupational Health Nurse.

Last Name	First	Middle Initial
<input type="text"/>		
Number & Street or Box Number		
<input type="text"/>		
Town/City	Prov	Postal Code
<input type="text"/>		

## 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 I also understand that any driver's licence issued to me may be withdrawn if I do not meet the medical requirements for the licence.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 \_\_\_\_\_  
Present Class of Licence \_\_\_\_\_ Present Endorsements \_\_\_\_\_ Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_  
Male  Female   
Class of driver's licence for which application is made \_\_\_\_\_

Name of Examining Physician \_\_\_\_\_ Office Telephone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Address \_\_\_\_\_ Postal Code \_\_\_\_\_ E-mail Address \_\_\_\_\_

## PHYSICIAN TO COMPLETE (below)

### A. VISION

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

Horizontal Fields of Vision by Confrontation (circle for each eye)		
Right	Normal	Restricted
Left	Normal	Restricted

Any ocular condition that could affect driving? (explain):

Other:

### 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 aid single:  Hearing aid bilateral
3. Vertigo: Controlled  Uncontrolled
4. Menieres: Controlled  Uncontrolled
5. Other:

### C. CARDIOVASCULAR

Normal

1. Overall Cardiac Status: Stable  Unstable
2. NYHA Classification:  
1-No Limitation  2-Mild  3-Moderate  4-Severe
3. CAD: Mild  Moderate  Severe
4. Angina Pectoris: Stable  Unstable
5. Hypertension: BP: \_\_\_\_\_ TX: \_\_\_\_\_
6. Myocardial Infarction: Date: \_\_\_\_\_ Type: \_\_\_\_\_  
Stable  Unstable
7. Heart Surgery/Procedures:  
 Angioplasty: Date: \_\_\_\_\_  CABG: Date: \_\_\_\_\_  
 Valve: Date: \_\_\_\_\_  Pacemaker: Date: \_\_\_\_\_  
 ICD: Insertion Date: \_\_\_\_\_ Last Discharge Date: \_\_\_\_\_  
Reason for ICD insertion: \_\_\_\_\_
8. Arrhythmias:
9. Peripheral Vascular Disease and Deficit(s):
10. Arterial Aneurysm: Location: \_\_\_\_\_ Current Size: \_\_\_\_\_
11. Investigations (i.e. stress test/METS, ECHO/EF%, etc.): Date: \_\_\_\_\_  
Results: \_\_\_\_\_
12. Other:

# Health History and Physical Examination

## D. CENTRAL NERVOUS SYSTEM

Normal

1. TIA: Date: \_\_\_\_\_ Deficits: \_\_\_\_\_
2. CVA: Date: \_\_\_\_\_ Deficits: \_\_\_\_\_
3. Memory changes: Yes  No  Diagnosis: \_\_\_\_\_
4. Head Injury: Date: \_\_\_\_\_ Deficits: \_\_\_\_\_
5. Syncope/Fainting/Blackouts: Date: \_\_\_\_\_  
Cause: \_\_\_\_\_
6. Craniotomy: Date: \_\_\_\_\_ Reason: \_\_\_\_\_
7. Progressive Disorders: Parkinson's  MS  ALS   
Huntington's  Other  Stable  Deficits
8. Seizure: Onset and Frequency: \_\_\_\_\_  
Diagnosis of Epilepsy: Yes  No   
Cause and Type of Seizures: \_\_\_\_\_  
Date of Last Seizure: \_\_\_\_\_  
Medications and Dosage: \_\_\_\_\_
9. Other (i.e., neuropathy, etc.): \_\_\_\_\_

## E. RESPIRATORY

Normal

1. Sleep Disorder diagnosed: Yes  No   
Type (i.e., OSA, Narcolepsy, etc): \_\_\_\_\_  
Investigations: \_\_\_\_\_  
Treatment: CPAP  Other (describe): \_\_\_\_\_
2. COPD: Mild  Moderate  Severe
3. Oxygen: Continuous  Supplementary
4. Other: \_\_\_\_\_

## F. METABOLIC - ENDOCRINE

Normal

1. Diabetes Mellitus: Yes  No  Date of onset: \_\_\_\_\_  
Insulin: Yes  No
2. Date of last episode of hypoglycemia: \_\_\_\_\_
3. Events of: LOC  3rd party intervention  Dates: \_\_\_\_\_
4. Hg A1C: \_\_\_\_\_ Date: \_\_\_\_\_
5. Hypoglycemic Unawareness: Yes  No
6. Complications related to diabetes (i.e., vision, organ failure, neuropathy, etc): \_\_\_\_\_
7. Other: \_\_\_\_\_

## G. MUSCULOSKELETAL

Normal

1. Amputation of: \_\_\_\_\_ When: \_\_\_\_\_
2. ROM: Normal  Impaired
3. Arthritis: Mild  Moderate  Severe
4. Disorder of Spine: \_\_\_\_\_
5. Other: \_\_\_\_\_

## H. PSYCHIATRIC

Normal

1. General psychiatric health: Stable  Unstable
2. Acute illness/episode (i.e., psychosis, harm with vehicle, mania):  
Date and type: \_\_\_\_\_
3. Last hospitalization Date: \_\_\_\_\_
4. Severe Depression: Yes  No
5. Treatment Compliance: Yes  No
6. Other (i.e., ADD, ADHD, FASD, etc): \_\_\_\_\_

## I. OTHER CONDITIONS

None

1. Substance/Alcohol Abuse: Yes  No   
Attended Rehab: Yes  No  Date: \_\_\_\_\_  
Related Seizures, cognitive or physical changes: Yes  No   
Explain: \_\_\_\_\_
2. Prescribed drugs or treatments that could impair (i.e. analgesics, medical marijuana, methadone, chemotherapy, radiation, etc.), explain: \_\_\_\_\_
3. Physiologic changes of age which could impair physical and/or mental status (i.e. changes to- response times, vision, joints, muscles, etc.), explain: \_\_\_\_\_
4. Cognitive screening completed: Yes  No   
Results included with report: Yes  No   
(i.e., Trails A & B, FAQ, MMSE, etc.)
5. Exam Findings:  
 Physical concerns identified regarding medical fitness to drive (explain): \_\_\_\_\_  
 Cognitive concerns identified regarding medical fitness to drive (explain): \_\_\_\_\_

## J. GENERAL CONCLUSION OF ANY FUNCTIONAL LIMITATION

1. Physical and/or cognitive impairment could affect individual's ability to safely operate a motor vehicle:  
 May drive pending SGI licensing decision  
 No driving pending SGI licensing decision
2. Recommendations for further assessment will be considered:  
 DCAT  SGI in-vehicle assessment  
 Full functional assessment through occupational therapist-based program (Saskatoon Driver Evaluation or Regina Driver Assessment)

Please enclose or list applicable investigations, results and treatments/medication (i.e., EEG, CT, etc.)

Date

Practitioner Signature and Status