



# Medical Assessment for Commercial Drivers with Insulin-treated Diabetes

**Note: To be completed by a qualified medical doctor familiar with your medical history.**

## Patient Information and Consent

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Address: \_\_\_\_\_ Telephone: Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_  
 \_\_\_\_\_ Postal Code: \_\_\_\_\_ Cellular ( ) \_\_\_\_\_  
 Master No: \_\_\_\_\_ Class of licence (*check one*): ① ② ③ ④

I certify that the information I have provided to the physician concerning my diabetes is accurate. I authorize the release of any information concerning my medical condition to the Motor Vehicle Administration Section.

\_\_\_\_\_  
 PATIENT'S/DRIVER'S SIGNATURE DATE

How long have you treated this patient for a diabetic condition? \_\_\_\_\_

Does patient experience severe hypoglycemic episodes (ie., severe mental confusion, seizures, coma) without warning?  Yes  No

If "Yes," please describe fully \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Within the past two years has patient suffered an episode of hypoglycemia?  Yes  No loss of consciousness?  Yes  No

If "Yes," please indicate the date(s) and type(s) of treatment (eg., self-treated, treated by another person or treated at the hospital) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Does patient have knowledge of the causes, symptoms, and treatment of hypoglycemia?  Yes  No

Does patient have any of the following complications:  Neuropathy  Retinopathy  Peripheral Vascular Disease  
 Nephropathy  Angina

Has patient followed your directions for the care of diabetes?  Yes  No

HgA1C level \_\_\_\_\_ Date performed \_\_\_\_\_

Blood glucose \_\_\_\_\_ Date Performed \_\_\_\_\_

Please give your opinion of the patient's ability to safely operate a **commercial** motor vehicle.

\_\_\_\_\_  
 \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Address: \_\_\_\_\_

City/Town: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

\_\_\_\_\_  
 PHYSICIAN'S SIGNATURE DATE