Ontario

Ministry of Transportation

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Medical Condition Report

Fee Schedule Code
K035

Report by a prescribed person in compliance with Subsection 203(1) or 203(2) of the *Highway Traffic Act*.
Please complete in full.

Mail or fax to: Medical Review Section, 77 Wellesley Street West, Box 589, Toronto ON M7A 1N3
Fax Number: 416-235-3400 or 1-800-304-7889 Telephone Number: 416-235-1773 or 1-800-268-1481

Fields marked with an asterisk (*) are mandatory. When a report of a mandatory condition is made it will result in a licence suspension.

Part 1. Patient Information

Last Name *	First Name *	Middle Init.	Date of Birth (yyyy/mm/dd) *

Current Address

Unit Number	Street Number *	Street Name or Lot *	PO Box	Province *

City/Town/Village *	Postal Code	☐ Male * ☐ Female *	Driver's Licence Number (if available):

Part 2. Practitioner's Information

Practitioner's Last Name *	Practitioner's First Name *

Practitioner's Address

Unit Number	Street Number *	Street Name *

City/Town/Village *	Province *	Postal Code

I am this person's: ☐ Family/Treating Physician ☐ ER Physician ☐ Nurse Practitioner ☐ Occupational Therapist
☐ Urgent Care/Walk In Clinic Physician ☐ Other _____

I have provided my patient or their legal representative with a copy of this report. ☐ Yes ☐ No

I approve of the ministry releasing this report to the patient or their legal representative if requested. ☐ Yes ☐ No

I wish to be notified if my patient requests a copy of this report from the ministry, as releasing this report may threaten the health or safety of the patient or another individual. ☐ Yes ☐ No

Practitioner's Signature	Date of Report Examination (yyyy/mm/dd)

Part 3. Medical Condition, Functional Impairment or Visual Impairment - Please check all diagnoses that apply.

1. Cognitive Impairment

This patient has or appears to have a disorder resulting in cognitive impairment that affects attention, judgement and problem solving, planning and sequencing, memory, insight, reaction time or visuospatial perception, and results in substantial limitation of the person's ability to perform activities of daily living.

Due to: ☐ Dementia ☐ Brain Injury ☐ Unknown ☐ Other (Specify) _____

2. Sudden Incapacitation

This patient has or appears to have a disorder that has a moderate or high risk of sudden incapacitation, or that has resulted in sudden incapacitation and that has a moderate or high risk of recurrence.

Due to:

- ☐ Aortic aneurysm - at the stage of imminent rupture
- ☐ Cerebral aneurysm
- ☐ Heart disease with Pre-syncope/syncope/arrhythmia
- ☐ Narcolepsy with uncontrolled cataplexy or daytime sleep attacks
- ☐ Obstructive sleep apnea – Untreated or Unsuccessfully Treated with Apnea-hypopnea index (AHI) of ≥20 with excessive daytime sleepiness

  Disponible en français

Patient Information

Last Name *	First Name *	Middle Init.	Date of Birth (yyyy/mm/dd) *

☐ Seizure due to:
☐ Alcohol Withdrawal ☐ Aneurysm ☐ Brain Tumour ☐ Epilepsy ☐ Stroke ☐ Intracranial Haemorrhage
☐ Other (Specify) _____

☐ Hypoglycaemia requiring intervention of a third party or producing loss of consciousness

☐ CVA resulting in:
☐ Physical Impairment ☐ Cognitive Impairment ☐ Visual Field Impairment. (If checked please complete section 4)

☐ Other (Specify) _____

3. Motor or Sensory Impairment

This patient has or appears to have a condition or disorder resulting in severe motor impairment that affects: coordination, muscle strength and control, flexibility, motor planning, touch or positional sense.

Due to:

☐ Central Nervous System Impairment
☐ CVA ☐ Parkinson's Disease ☐ Multiple Sclerosis ☐ Spinal Cord Injury ☐ Other (Specify) _____

☐ Peripheral Nervous System Impairment
☐ ALS ☐ Nerve Injury ☐ Polyneuropathy ☐ Other (Specify) _____

☐ Other (Specify) _____

4. Visual Impairment

This patient has or appears to have:

☐ Best corrected visual acuity below 20/50 with both eyes open and examined together

☐ A visual field that is less than 120 continuous degrees along the horizontal meridian, or less than 15 continuous degrees above and below fixation, or less than 60 degrees to either side of the vertical meridian, including hemianopia.

☐ Diplopia that is within 40 degrees of fixation point (in all directions) of primary position, that cannot be corrected using prism lenses or patching.

Eyes	Without Correction	With Correction	Visual Field
Right	20/	20/	☐ Full ☐ Restricted
Left	20/	20/	☐ Full ☐ Restricted
Combined	20/	20/	☐ Full ☐ Restricted

Due to (check any that apply):

☐ Retinitis Pigmentosa ☐ Glaucoma ☐ Diabetic Retinopathy ☐ CVA ☐ Acquired Brain Injury ☐ Unknown
☐ Other (Specify) _____

5. Substance Use Disorder

This patient has or appears to have a diagnosis of an uncontrolled substance use disorder, excluding caffeine and nicotine, and is non-compliant with treatment recommendations.

☐ Alcohol ☐ Other Substances (Specify) _____

Recommended form of treatment is: ☐ Outpatient Intensive ☐ Residential

6. Psychiatric Illness

This patient has or appears to have a condition or disorder currently involving any of the following: **acute psychosis**, severe abnormalities of **perception**, or has a **suicidal plan** involving a vehicle or an intent to use a vehicle to harm others.

Due to: ☐ Major Depressive Disorder ☐ Bipolar Disorder ☐ Anxiety Disorder ☐ Personality Disorder
☐ Schizophrenia or other Psychotic Disorder ☐ Other (Specify) _____

7. Discretionary report of medical condition, functional impairment or visual impairment

In the opinion of the prescribed person, this patient has or appears to have a medical condition, functional impairment or visual impairment that may make it dangerous for the person to operate a motor vehicle and is being reported pursuant to Section 203(2) of the *Highway Traffic Act*.

Please describe condition(s) or impairment