Centre intégré de santé et de services sociaux de la Gaspésie
Québec

801278

Last name		First name
Date of birth	**Age**	**Gender**
	years	☐ Female ☐ Male
Health insurance card number		**Expiration**
Spoken language(s)		
☐ French ☐ English ☐ Other :		

APPLICATION :

☒ CRDI-TSA-DP

SERVICE REQUEST
Driving assessment and adaptation of road vehicles

USER IDENTIFICATION

Address (civic number, street, city)	Postal code

Phone	Cell phone	Email

Living arrangement (currently)

☐ At home : ☐ Alone ☐ With (specify) :

☐ Foster care type resource : ☐ Type resource ☐ Other (specify) :

RELATED PERSONS

Name	Relationship
	☐ Parent/Guardian ☐ Other (specify) :

☐ Same as user

Address (if different of user)	Postal code

Phone	Cell phone	Email

COMPENSATION PLAN (IF APPLICABLE)

Date of event (yyyy-mm-dd)	Reference number

Source

☐ SAAQ ☐ CSST ☐ MSSS ☐ Other (specify) :

Advisor/Agent	Contact details

MEDICAL AND PROFESSIONAL INFORMATION

Related diagnosis to the reference	Date of occurrence (yyyy-mm-dd)
Secondary diagnosis(s) or associated conditions	**Date of occurrence (yyyy-mm-dd)**

DRIVER ET PASSENGER

Driver (must have a valid driving license)

☐ Driving ability assessment *(specify your doubts, difficulties and needs)* :	☐ Vehicle access assessment *(specify difficulties and needs) :*

Passenger (specify difficulties)

Last name : _____ First name : _____ File number : _____

MOBILITY

Mobility aid

☐Manual folding frame W/C ☐Motorized W/C ☐Walking cane ☐Walker
☐Manual rigid frame W/C ☐4 wheels scooter ☐3 wheels scooter ☐Other (specify brand and year) :

SAAQ DRIVING RECORD (OR DRIVING LICENSE)

Driver's SAAQ file	Class
Restrictions	**Date issued (yyyy-mm-dd)**

Driving

Referred person is currently driving :
☐Yes ☐No, for wich reason ?

Medical declaration to the Medical Evaluation Department of the SAAQ :
☐Yes ☐No, for wich reason ?

An M-57 was requested by the SAAQ medical service :
☐Yes, include expiration date (yyyy-mm-dd) : ☐No

CURRENT VEHICLE

Brand	Model	Year
Transmission	**Specialised equipment**	
☐Automatic ☐Manual		

Planned change of vehicle

☐No ☐Yes, specify : _____
☐The user is advised that he must purchase his new vehicle within three months of the evaluation

REFERRED PERSON AUTORISATION

Is the referred person informed of the request of service?

☐Yes ☐No, for wich reason ?

REFERRER

Name	Phone	Extension
Profession	**Institution**	
Address		**Postal code**

_____ Signature of the referrer

_____ Date

REQUIRED DOCUMENTS

Driver

- Copy of M-28 less than one year old, the completed original of which has been sent to the SAAQ;
- Copy of M-5, if applicable;
- Occupational therapist's report less than two years old;
- If applicable, the user is advised that he must purchase his new vehicle within three months of
- his assessment and not before;
- Copy of the registration form sent to the SAAQ financial assistance program.

Passenger

- Medical report or psychoeducational assessment report less than two years old.

**** If possible, a physiotherapist's and/or neuropsychologist's report less than 2 years old.***

Please send the service request to : peeca.cisssgaspesie@ssss.gouv.qc.ca