

Medical Condition Report



Section 203 of the Highway Traffic Act requires that all legally qualified medical practitioners must report to the Registrar of Motor name, address and clinical condition of any patient sixteen years of age or older who, "is suffering from a medical condition that may dangerous for the person to operate a motor vehicle". To simplify the reporting process, the Ministry of Transportation has created
Mail or fax to: Registrar of Motor Vehicles, Medical Review Section, Ministry of Transportation, 2680 Keele Street, Downsview, ON M3M 3E6.
No.: 416-235-1773 or 1-800-268-1481. Fax No.: 416-235-3400 or 1-800-304-7889.

Patient Information

Last Name	First Name	Middle Initial	Fee Sche
			KK
Street No. and Name or Lot, Con. and Twp.			Apt. No.
City, Town or Village			Postal Code
Date of Birth	Male	Female	Driver's Licence No. (if available)
Y M D			

For your convenience, the following is a list of the more common medical conditions that are reported to M marked with an "X". If the condition you are reporting is not listed, please indicate it in the section marked "O"

- | | |
|--|--|
| <input type="checkbox"/> Alcohol Dependence | <input type="checkbox"/> Visual Field Impairment |
| <input type="checkbox"/> Drug Dependence | <input type="checkbox"/> Diabetes or Hypoglycemia or other metab |
| <input type="checkbox"/> Seizure(s)-Cerebral | <input type="checkbox"/> Uncontrolled |
| <input type="checkbox"/> Seizure(s)-Alcohol related | <input type="checkbox"/> Mental or Emotional Illness-Unstable |
| <input type="checkbox"/> Heart disease with Pre-syncope/Syncope/Arrhythmia | <input type="checkbox"/> Dementia or Alzheimer's |
| <input type="checkbox"/> Blackout or Loss of consciousness or Awareness | <input type="checkbox"/> Sleep Apnea-Uncontrolled |
| <input type="checkbox"/> Stroke/TIA or head injury with significant deficits | <input type="checkbox"/> Narcolepsy-Uncontrolled |
| <input type="checkbox"/> Both Visual Acuity and Visual Field Impairment | <input type="checkbox"/> Motor Function/Ability Impaired |
| <input type="checkbox"/> Visual Acuity Impairment | <input type="checkbox"/> Other (specify): _____ |

Optional

To expedite your patient's file, please provide further elaboration of clinical condition (if available) or attach as a separate report: Diagn Relevant Clinical Information (i.e. current status - including results of investigations, medication(s), treatment and prognosis); and whether or the condition is a serious risk to road safety, threat to road safety is unknown or condition is temporary - weeks/months.

Date of examination upon which this report is based: Y M D How long has this person been your patient?

- ☐ Patient is aware of this report.
- ☐ I wish to be notified if my patient requests a copy of this report, as releasing this report pursuant to a request under the Freedom of Information Act may threaten the health or safety of the patient or another individual.

Physician's Last Name, First Name and Middle Initial

For MTO L
030