

Cognitive Assessment Report



SGI pays the complete cost for requested medical reports, billing code 74A.
You will not be charged an additional fee by your practitioner.

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: 306-775-6176
Toll Free Fax: 1-866-274-4417 or 306-347-2577
mruinquiries@sgi.sk.ca

Please print

Part 1 - Customer Information		Last Name	First Name	Middle Initial	Date of Birth
					DD MMM YYYY
Address			Customer Number		Class of Licence

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 allow my practitioner 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 I also understand that any driver's licence issued to me may be withdrawn if I do not meet the medical requirements for the licence.

Customer signature: _____

Date: _____
DD MMM YYYY

Phone: _____

Part 2 - Practitioner Information

Name and contact information: _____

Designation:

- Physician
 Nurse Practitioner
 Occupational Therapist

Patient in my care since _____

Part 3 - Assessment Information

Please address the following points to the best of your ability:

Cognitive diagnosis and onset: _____

Related treatment and/or medication _____

Is the impairment expected to be temporary (likely to resolve in 3-6 months)?
 Yes No Unknown

Could current medication / treatment result in:
 Sedation or Psychomotor slowing
 Impairment of Concentration/Attention
 Impairment of Judgment
 Blurred or Double Vision

Has your patient been referred for further assessment?
 Yes No
Type: _____

Which of the categories listed below best describes your patient's cognitive status, **check one only**:

- Some memory impairment - no definitive diagnosis**
-forgets names, location of objects
-may have trouble finding words
-may have difficulty travelling to new locations
-may have difficulty handling problems at work
- Mild impairment**
-has difficulty with complex tasks or instrumental activities of daily living (such as finances, shopping, planning dinner, cooking, taking medication, telephoning, etc.)
- Moderate impairment**
-has difficulty with performing two (2) or more *instrumental activities of daily living* (including medication management, banking, shopping, telephone use, cooking, etc.) or any *basic activity* (including eating, dressing, hygiene)
-needs help choosing and putting on clothing, assistance with bathing, etc
-has gotten lost and or disorientated while driving
- Severe impairment**
-decreased ability to use toilet, or is incontinent
-vocabulary limited
-loses ability to walk and sit
-unable to smile

Additional medical conditions? (please list) _____

Related treatment/prescriptions? (please list) _____

Cognitive screening test(s) conducted (e.g. MMSE, MoCA, Trail A, Trail B, Clock Drawing, FAQ, etc.) Yes No **(Include results with form)**

Additional comments to take into consideration: _____

Thank-you for completing this report, the information will be reviewed with our customer's file and a licensing decision will be made.

Practitioner signature: _____

Date: _____
DD MMM YYYY