CONFIDENTIAL MEDICAL REPORT

In respect of a Disability Claim

Dear Doctor
This report is in respect of a disability claim that has been submitted by this patient. Please do not under any circumstances show the claimant the report with out first cosulting with the fund. The report should be faxed to 021 686 5770 and a hard copy must be posted to P O Box 291248, MELVILLE, 2109. Please retain a copy for your records. Thank you for your assistance in this matter.

1. Medical Practitioners Details

Name:……Qualifications/Specialty……

Work postal address: ……

Telephone number ( ) ……Fax number ( ) ……

2. Claimant's Details

Full name: ……

Identity number: ……

Industry number: ……

Company number:……

3. Consultation History

Date of your first ever consultation with Claimant: ……

Date of your first consultation with regards to the current symptomatology:……

Date of your last consultation with the claimant:……

4. Medical References

Please give the details and any other Practitioners, Specialists or Hospitals to whom the Claimant has been referred. Please include copies of all available Specialist reports.

Name of Practitioner/Hospital			
Specialty			
Postal address			
Complaints referred for			

5. Medical History

Please give a full history, including the following:

- Symptoms and diagnoses
- Dates of any diagnoses
- Clinical details indicating severity and permanence
- Relevant test results (e.g. CD4 count, HIV result, lung function readings, X-ray or scan results)
- Treatment and response
- Comments on compliance

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Current major complaint(s):

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6. Results of most recent examination

Date of Examination:……
Please give full clinical details as at that examination, including height, weight and blood pressure readings. Please include details of any limitations evident at that examination (e.g. joint limitations, visual acuity)

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7. Prognosis

What are the chances of recovery (good/fair/poor/nil)? ……
Are any residual problems likely? ***Please specify***

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8. FUNCTIONAL ABILITIES

Please comment on the member's ability to carry out the specified activities in the table below:

Activity	**Current limitations**				**Expected future ability**		
	No limitations	Partial limitations	Impossible	Danger to self or others	Improve	Remain constant	Deteriorate
Seated/sedentary tasks							
Clerical/administrative tasks							
Thinking clearly & making decisions							
Interacting with others							
Supervising other							
Walking (non-strenuous) over level ground							
Walking (strenuous) over uneven ground							
Climbing							
Kneeling							
Standing							
Bending							
Operating light machinery							
Operating heavy machinery							
Working with heavy weights							
Working with light weights							
Driving a light motor vehicle							
Light manual labour							
Heavy manual labour							
Use both hands							
Use of fine coordination							
Work in cramped conditions							
Work in dusty environments							
Work in a fume environment							

General comments which may clarify the responses in the table. If improvement is expected, please indicate the time period in which that improvement is anticipated:

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9. Treatment and Rehabilitation

Current medication regime. ***Please specify all medications and dosages.***

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Other treatment the claimant has received or is currently receiving

(e.g. physiotherapy, occupational therapy, psychotherapy)

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Planned future treatment, including surgery:

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Your recommendations regarding rehabilitation (if applicable):

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Please attach copies of any correspondence received from Practitioners, Specialists or Hospitals in respect of the claimant.

DECLARATION
I hereby declare that I have personally examined ad attended to the claimant and that the content of this report are true and correct.

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SIGNED **DATE**