

# DISABILITY BENEFIT APPLICATION FORM



PART THREE : CONFIDENTIAL MEDICAL REPORT												
(This form to be completed by the member's private doctor whom they consult with)												
<p>Your patient has submitted a disability application. To enable us to assess the claim we require of you to complete this report. The report will assist us in understanding the patient's degree of impairment and to ascertain diagnosis, Alterations(s) of functional capacity due to illness or injury and optimal medical treatment.</p> <p>Please attach copies of any medical reports or results of investigations to substantiate the medical conditions/s of your patient.</p> <p>The cost of the report is for your patient's account.</p> <p>Please record full and accurate answers and be sure to answer all questions.</p>												
1. GENERAL PARTICULARS OF THE PATIENT												
Surname:												
First Name:												
Date of Birth:	Y		Y		/	M		/	D			
Patient's ID Number:												
Employer Name:												
Fund / scheme name:												
Occupation:												
2. DETAILS OF PERSONAL MEDICAL ATTENDANT												
Name of personal medical attendant:												
Name of medical Practice or clinic:												
Practice Number:												
How long have you attended to the patient?												
How far do the records, which you hold, go back?												
When was medical advice last sought and why?												
3. HISTORY OF ILLNESS OR ACCIDENTS												
Main diagnosis and cause of disablement												
Detail the onset and history of the illness / Injury:												
What are the resultant limitations experienced:												
Please provide details of any complications or concurrent conditions:												
Are you still attending to the patient											Y	N
Does the patient have insight into his / her illness?											Y	N

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4. MEDICATION				
Is any treatment by drugs or otherwise being given at present?			Y	N
If so, please give details:				
Please comment on the patient's compliance to treatment / medication:				
5. DETAILS OF BLOOD TESTS, URINE TESS, ECG, X-RAY OR OTHER INVESTIGATIONS				
Date	Nature of condition	Treatment	Duration	
6. DETAILS OF FUNCTIONAL OR OCCUPATIONAL ABILITY				
Has any of the following contributed in any way to the patient's disablement?				
Nature of contributor	Yes	No	Details	
Previous illness or injury	Y	N		
Hazardous pursuit or pastime	Y	N		
Habits e.g excessive alcohol consumption	Y	N		
Self-inflicted injuries	Y	N		
When was the patient last able to perform his / her job?				
If the patient is temporarily unable to perform his / her occupational duties, when do you expect the patient to perform his / her occupational duties?				
Some duties				
All duties				
If the patient is permanently unable to perform his / her occupational duties, please comment on other types of work he / she may be capable of performing:				
What further rehabilitation is envisaged for the patient?				

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7. ADDITIONAL INFORMATION								
Are you aware of any other medical information relating to the patient which could be important in the assessment of the claim:								
18. PERSONAL MEDICAL ATTENDANT DECLARATION								
I declare that all the information provided is correct and true. I accept that a copy of this report can be made available to other parties, such as medical practitioners, other insurers and/or legal representatives.								
Please send this confidential report without delay to medworx by e-mail: <a href="mailto:admin@medworx.co.za">admin@medworx.co.za</a> or call us on (011) 463 4755.								
Signed at		Dated		this		Day of		20
Signature of medical Examiner		Qualifications		Year of first qualifying				
Full postal address of medical examiner and telephone number								