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DISABILITY/FUNCTIONAL IMPAIRMENT BENEFIT CLAIM FORM – MEDICAL REPORT

How to Complete this Application Form

Dear Health Professional

Please answer each question in full. Do not use a dash, correction fluid or leave blank. Include copies of test results and reports for example pre- and post-operation reports, history reports, blood test results, x-ray reports, ECG and scans to support the diagnosis. The **claimant** is responsible for the cost of the initial medical report.

Section 1. Health Professional Details

Surname	
First Name(s)	
Qualifications/Speciality	
Other Qualifications	
Practice Number	
HPSCA Registration No.	
Practice Address	
	Code
Telephone Number (W)	
Telephone Number (F)	
Cellphone Number	
Email Address	

Section 2. Claimant Details

Surname	
First Name(s)	
Maiden Name or previous name	
ID Number	
Date of Birth	Y Y Y Y M M D D
Country of Origin	
Hospital or File Number	
Name of Employer	
Telephone Number	
Cell Number	

Section 2. Claimant Details

Are you treating the claimant for the impairment that gave rise to this claim? Yes ☐ No ☐

Date of First Consultation | Y | Y | Y | Y | M | M | D | D |

Date of your First consultation with regards to the current symptomology | Y | Y | Y | Y | M | M | D | D |

History of Dates and reasons for consultations

Dates	Reasons

How frequently do you see the member (eg. once a month)

Please give details of diagnosis of the illness/accidents for which you have attended since the member was referred to you?

Diagnosis:		Y	Y	Y	Y	M	M	D	D
Diagnosis:		Y	Y	Y	Y	M	M	D	D
Diagnosis:		Y	Y	Y	Y	M	M	D	D

What are the co-morbid and underlying conditions?

When did the symptoms appear?

Has the claimant ever been treated for a similar condition, or any other medical condition that may have contributed to this impairment? Yes ☐ No ☐

If “Yes” please provide details and dates:

Do you have the results and reports of special investigations for example histology reports, CD4 Count results, blood tests, x-ray reports, ECG, EEG, MRI scan reports, etc.? Yes ☐ No ☐

If “Yes”, please include the copies of these as well as copies of any other reports and file relating to this impairment.

Please provide names, dates, and contact details of other health professionals the claimant has been referred to for this and any other conditions:

Name	Date	Contact Number

What are the complications the claimant has suffered?

Have any of the following contributed to claimant's condition?

Abuse of ethanol, alcohol, or drugs (legal and illegal) Yes ☐ No ☐

Attempted suicide Yes ☐ No ☐

War, riot, and terrorism Yes ☐ No ☐

Participation in hazardous sports or leisure pursuits Yes ☐ No ☐

If "Yes" to any of the above, please provide the details:

Has the claimant ever been tested for or received medical counselling, advice, or treatment in connection with any sexually transmitted diseases, including Hepatitis B or HIV-related conditions? Yes ☐ No ☐

If "Yes" to any of the above, please provide the details:

Please elaborate on any family history which may have led to the claimant's condition:

Section 4. Current Medical Status

Current major complaints

Describe fully the claimant's current symptoms.

Please give a full clinical and objective evidence for example general look, height, weight, blood pressure, heart sound about the claimant's current health, symptoms, and impairments.

Corrected visual acuity.

Limitations evident at the examination (eg. Range of movement, mental state, etc.)

Describe in detail the nature and extent of the member's impairment.

Clinical details indicating severity and permanence.

Provide the outcome of any other specialist's consultations, if applicable. Please enclose copies of available specialist medical reports.

Give dates and outcome of any test/investigations done to diagnose/quantify the members' condition. Please enclose copies of any reports/investigations done.

For psychiatric claims, please provide the DMS IV 5 Axis diagnosis.

Axis I	
Axis II	
Axis III	
Axis IV	
Axis V	

For psychiatric claims, please provide details and comment on any family history of mental illness.

For psychiatric claims, please provide the clinical examination/mental state examination findings. Please record general appearance, mood, anxiety, psychotic features, mental state, cognitive and social functioning etc.

Treatment and Rehabilitation:

Please describe the previous and current treatment that the member has/is receiving for his/het condition. Please include names, dosage, and dates/duration of all medication.

Medicines	Current/Previous	Dosages	State Date and End Date

Is the current treatment and medication adequate for the claimant's condition? Yes ☐ No ☐

What is the success rate or effectiveness of the claimant's current treatment?

Are there any other treatment or rehabilitation that the claimant has received or is currently receiving for example: physiotherapy, occupational therapy, psychotherapy, etc.?

Is there any other treatment, which the claimant could benefit from, but cannot afford or does not have access to? Please comment.

Please advise regarding planes future treatment. Refer to medication, surgery, rehabilitation, etc. and provide dates.

Please provide any details of any previous or current hospital admissions. Kindly indicate the date of admission and discharge and reason for admission.

Admission Date	Discharged Date	Reasons for Admission

Please comment on any occupational therapy assessments, functional assessments or vocational rehabilitation received and the outcome thereof.

In your opinion, is the condition one that would benefit from any form of active rehabilitation? Yes ☐ No ☐

If "Yes", please provide suggestions/details of rehabilitation that would be of benefit.

In your opinion, is the treatment optimal? Yes ☐ No ☐

If “No”, suggest possible alternative therapy, medication, rehabilitation, or surgery that may be attempted to maximize management.

Compliance to treatment:

Comment on the member’s compliance with treatment (medication, therapy/rehabilitation, follow up consultations etc.). If not compliant, please advise why not.

Has the condition stabilized or regresses since onset? Please provide substantiating details.

Prognosis:

What are the chances of recovery for example good, fair, poor, and nil.

Provide the member’s short term and long-term prognosis with supporting reasons.

In your experience, can you give an indication of the expected recovery period necessary for this member and his/her condition?

Are any residual problems likely? Yes ☐ No ☐

If “Yes”, please give details:

Brief details of claimant's current occupation (job title and duties)

In your opinion what was the last date that the member was actively able to work?

Y	Y	Y	Y	M	M	D	D

Please specify why, in your opinion, the member is finding it difficult to perform his/her current occupation and which specific functions of his/her occupation he/she cannot perform?

What functions can the member still perform?

When is the member expected to be able to return to work?

Y	Y	Y	Y	M	M	D	D

Functional Limitations of Abilities

Please comment on the claimant's current and expected future ability to carry out specified activities in the below table:

Activity	Current Limitations				Expected Future Ability		
	No Limitations	Partial Limitation	Impossible	Danger to self or others	Improve	Remain Constant	Deteriorate
Seated/Secretary Tasks							
Clerical/Administrative tasks							
Manage and making decisions							
Interacting with others							
Supervising others							
Walking on level terrain							
Walking on uneven terrain							
Climbing							
Kneeling							
Bending							
Standing							
Lifting							
Pushing and Pulling							
Operating light machinery							
Operating heavy machinery							

Activity	Current Limitations				Expected Future Ability		
	No Limitation	Partial Limitation	Impossible	Danger to self or others	Improve	Remain Constant	Deteriorate
Working with heavy weights							
Working with light weights							
Light Manual Labour							
Heavy Manual Labour							
Driving							
Use of both hands							
Use of fine co-ordination							
Work in cramped conditions							
Work in dusty environment							
Work in fume environment							

Please provide any general comments which may clarify the response in the table. If improvement is expected, please indicate the period within which that improvement is anticipated.

Please comment on the claimant's ability to perform activities and daily living and self-care tasks. Advise what is and what is not possible.

Comment on the claimant's current daily activity profile i.e., how does the claimant spend his/her time at present?

Section 5. Declaration

I, ____, hereby declare that I have personally examined and attended to the claimant and that the contents of this report are true and correct.

Signed at ____ on

Y	Y	Y	Y	M	M	D	D

Signature

Doctor's Stamp

Please include the results and reports of special investigations for example histology reports, CD4 count results, blood test results, x-ray reports, ECG, EEG and MRI scan reports.

Please return the completed form to Triarc (PTY) LTD
medicaluw@triarc.co.za