

Spouse disability benefit - confidential medical report

Treating specialist to complete this form

Dear Doctor

The medical information requested in this form is in support of a claim for disability benefits provided by the applicant's spouse's employer. Your expertise and advice will provide a vital link in the process of assessing the claim.

As this is an extremely stressful time for the applicant, we would appreciate your speedy assistance with this matter. Thorough completion of this form will enable us to finalise the claim without unnecessary delays.

We thank you in anticipation for your co-operation.

As this report is in support of a claim application, any cost in connection with this report will be for the account of the policyholder. Momentum will not be liable for any cost in connection with completing this report.

Please ensure that copies of all clinical / diagnostic test results and specialist reports etc. are attached hereto.

Completed form together with supporting documents to be faxed to 021 917 3711 or emailed to wcc@momentum.co.za or posted to PO Box 2212, Bellville, 7535, attention Momentum Group Insurance disability claims.

1. Scheme details.

Scheme name

Employer name

2. Main member details.

Title

Initials

First name/s

Surname

Date of birth

 - -

RSA ID

ID / Passport no

Passport country of origin

Gender

3. Applicant (Spouse) details.

Title

Initials

First name/s

Surname

Date of birth

 - -

RSA ID

ID / Passport no

Passport country of origin

Gender

4. Medical practitioner's details

Name of doctor	<input type="text"/>		
Qualifications/speciality	<input type="text"/>		
Hospital / Practice name	<input type="text"/>		
Practice number	<input type="text"/>		
Telephone	<input type="text"/>	Fax	<input type="text"/>
Email	<input type="text"/>		
Address	<input type="text"/>		
	<input type="text"/>	Postal code	<input type="text"/>

5. Consultation history

Date of your first ever consultation with the applicant	<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Date of your first consultation with regard to the current symptomology	<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Date of your last consultation with the applicant (prior to current consultation)	<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Date of current consultation and examination	<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
How frequently do you see the applicant (e.g. once a month)	<input type="text"/>								

6. Medical references

Please give the details of any other practitioners, specialists or hospitals that the applicant has been referred to.

Name of practitioner / hospital	<input type="text"/>	<input type="text"/>	<input type="text"/>
Speciality	<input type="text"/>	<input type="text"/>	<input type="text"/>
Postal address	<input type="text"/>	<input type="text"/>	<input type="text"/>
Tel no.	<input type="text"/>	<input type="text"/>	<input type="text"/>
Complaints referred for	<input type="text"/>	<input type="text"/>	<input type="text"/>
Date referred	<input type="text"/>	<input type="text"/>	<input type="text"/>

7. Details of medical condition

a. Please give details of the illnesses/accidents for which you have attended since the applicant was referred to you.

b. Diagnosis and Date of diagnosis.

Date of Diagnosis	Diagnosis	ICD10 Code
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

c. For psychiatric claims, please detail the applicant's diagnosis using either the DSM IV or DSM V criteria.

d. Please provide a brief history of the applicant's condition.

e. Please provide details of any current or previous substance abuse, if applicable.

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

g. Results of current medical examination

Dominance (R / L)

Height (without shoes)

m

cm

Weight (in clothes, without shoes)

kg

Blood pressure (To be taken in recumbent posture. Exact reading to be given.)

Systolic

mm.Hg

Diastolic

mm.Hg

If the BP is 140/90 or higher, please record a second reading, preferably at the end of the examination.

Systolic

mm.Hg

Diastolic

mm.Hg

Corrected visual acuity.

Limitations evident at the examination (e.g. range of movement, mental state etc.).

Current major complaint/s as per the applicant.

h. 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.

i. Describe fully the applicant's current symptoms.

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

k. Clinical details indicating severity and permanence.

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

m. Give dates and outcome of any tests/investigations done to diagnose/quantify the applicant's condition. Please enclose copies of any reports / investigations done.

n. For psychiatric claims, please provide the results of any bedside cognitive assessments (e.g. but not limited to MMSE).

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

p. Please give details of any previous and current adjuvant therapy e.g. physiotherapy, psychotherapy etc. Please indicate dates, frequency and duration of any additional therapy received.

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

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

s. Please comment on the effectiveness of treatment/applicant's response to treatment.

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

u. 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.

v. In your opinion is the treatment optimal?

 Yes No

If no, suggest possible alternative therapy, medication, rehabilitation or surgery that may be attempted to maximise management.

w. Comments on the applicant's compliance with treatment (medication, therapy/rehabilitation, follow up consultations etc.).
If not compliant, please advise why not.

x. Has the condition stabilised or regressed since onset? Please provide substantiating details.

y. Provide the applicant's short term and long term prognosis with supporting reasons.

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

aa. Are any residual problems likely?

Yes

No

If yes, give details.

ab. Brief details of applicant's current occupation (job title and duties).

ac. In your opinion what was the last date that the applicant was last actively able to work?

D	D	-	M	M	-	Y	Y	Y	Y
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ad. Please specify why, in your opinion, the applicant is finding it difficult to perform his/her current occupation and which specific functions of his/her occupation he/she cannot perform?

ae. What functions can the applicant still perform?

af. When is the applicant expected to be able to return to work.

D	D	-	M	M	-	Y	Y	Y	Y
---	---	---	---	---	---	---	---	---	---

ag. To your knowledge, has the applicant submitted a request to the employer to have his/her normal duties adapted in any way (working hours/work station/working environment etc) to suit the medical condition? If yes, please provide details.

ah. What adaptations would you recommend?

8. Functional abilities

Please comment on the applicant's current and expected future 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 and making decisions							
Interacting with others							
Supervising others							
Walking (non-strenuous) on level terrain							
Walking (strenuous) on uneven terrain							
Climbing							
Kneeling							
Standing							
Bending							
Operating light machinery							
Operating heavy machinery							
Working with heavy weights							
Working with light weights							
Driving a light motor vehicle							
Driving a heavy motor vehicle							
Light manual labour							
Heavy manual labour							
Use of both hands							
Use of fine coordination							
Work in cramped conditions							
Work in a dusty environment							
Work in a fume environment							

Please provide any general comments which may clarify the responses in the table. If improvement is expected, please indicate the time-frame (period) within which that improvement is anticipated.

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

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

9. Supporting documents required

a. I have enclosed copies of all clinical investigation reports

Yes

No

b. I have enclosed copies of correspondence from other practitioners, specialists or hospitals

Yes

No

10. Declaration.

I declare that I have personally examined and attended to the applicant and that the contents of this report are true and correct.

Signature of
Medical Practitioner

Date - -

Options to sign the form:

1. Print out the form, sign and scan it and send it back via email to wcc@momentum.co.za , fax it to Fax +27 (0)21 917 3711 or posted to PO Box 2212, Bellville 7535, attention Momentum Group Insurance disability claims.
2. Place your scanned signature in the signature block by following the steps outlined below.
 - Store your scanned signature as a PDF document in a safe place on your computer.
 - Select the 'comments' tab from your menu in Adobe.
 - Select the 'add stamp' icon.
 - Select custom stamps.
 - Create custom stamps.
 - You can now browse and upload your signature to save it as a custom stamp under 'sign here' in Adobe.
 - You can now go back to your 'stamps' icon and select 'sign here' and select your saved signature.
 - Place it in the document and save the document.

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