momentum
corporate

Disability claim - 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 member'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 member, 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. Member details

Title		Initials	
First name/s			
Surname			
Date of birth	D D - M M - Y Y Y Y		
RSA ID	Yes ☐ No ☐	ID/Passport No.	
Passport country of origin			
Gender	Male ☐ Female ☐		

3. Medical practitioner's details

Name of doctor			
Qualifications/speciality			
Hospital / Practice name			
Practice number			
Address			
		Postal code	
Telephone		Fax	
Email			

4. Consultation history

Date of your first ever consultation with the member D D - M M - Y Y Y Y

Date of your first consultation with regard to the current symptomology D D - M M - Y Y Y Y

Date of your last consultation with the member (prior to current consultation) D D - M M - Y Y Y Y

Date of current consultation and examination D D - M M - Y Y Y Y

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

5. Medical references

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

Name of practitioner / hospital			
Speciality			
Postal address			
Tel no.			
Complaints referred for			
Date referred			

6. Details of medical condition

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

b. Diagnosis and Date of diagnosis.

Date of Diagnosis	Diagnosis	ICD10 Code
D D - M M - Y Y Y Y		
D D - M M - Y Y Y Y		
D D - M M - Y Y Y Y		
D D - M M - Y Y Y Y		

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

d. Please provide a brief history of the member'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

Details of medical condition (continued)

Corrected visual acuity.

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

Current major complaint/s as per the member.

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 member's current symptoms.

j. Describe in detail the nature and extent of the member'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 member'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 member has/is receiving for his/her condition. Please include names, dosage and dates/duration of all medication.

Details of medical condition (continued)

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/member'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 member'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 member'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 member and his/her condition?

Details of medical condition (continued)

aa. Are any residual problems likely? Yes ☐ No ☐

If yes, give details.

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

ac. In your opinion what was the last date that the member was last actively able to work? D D - M M - Y Y Y Y

ad. 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?

ae. What functions can the member still perform?

af. When is the member expected to be able to return to work. D D - M M - Y Y Y Y

ag. Has the member made any requests for or been offered reasonable accommodation at work? Please provide details.

7. Functional abilities

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

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

8. Supporting documents required

I have enclosed copies of all clinical investigation reports	Yes ☐	No ☐
I have enclosed copies of correspondence from other practitioners, specialists or hospitals	Yes ☐	No ☐

9. Declaration

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

Signature of Medical Practitioner

D D - M M - Y Y Y Y

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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