**REF No 203**

# Medical Specialist Examination Form

**(To be completed by the Claimant's Medical Specialist)**

## For

# SOUTH AFRICAN LOCAL AUTHORITIES PENSION FUND MEMBERS

NOTE: The completed Medical Specialist Examination Form and supporting documents (refer to checklist) to be forwarded by the Employer via registered post to:

The Soma Initiative (Pty) Ltd, P.O Box 2475, Clareinch, 7740

**GLA Death, Family Funeral and Disability: Monthly Income Benefits Underwritten by Prosperity Insurance**

## IMPORTANT NOTES AND CHECKLIST:

- **The cost of this report is for the claimant's account**
- **All answers to be in print**
- **Please complete ALL Questions – if a question is not applicable please mark "N/A" or "Unknown"**
- **Attach / include the documents required by SOMA as per the checklist hereinafter**
- **Information on this sheet can be filled in by hand or electronically**
- **For any queries please contact the Soma Help Desk on (021) 671 1977**

| | | |
|---|---|---|
| **CHECKLIST OF DOCUMENTATION REQUIRED BY SOMA** | All available supporting Medical Reports, X-rays, Special Investigations etc. | |

**IMPORTANT: THE DETAILED COMPLETION OF THIS DOCUMENT IS IMPERATIVE IN THAT IT CONSTITUTES A VITAL COMPONENT OF THE ASSESSMENT DATA AND PLAYS A SIGNIFICANT ROLE IN THE OUTCOME OF THIS CLAIMANT'S DISABILITY / INCAPACITY APPLICATION.**

## CLAIMANT DETAILS

| | |
|---|---|
| **Claimant's Full Name (Please print)** | |
| **Name of Employer** | |
| **Identity Number** | |
| **Date of Birth** | |

**PLEASE INDICATE**

1. **Are you the claimant's usual Medical Specialist?**

_____

2. **If not, why have <u>you</u> been requested to complete this form?**

_____

_____

3. **On what date did the claimant first consult you in connection with this disability/incapacity:**

_____

4. **Date on which the claimant last consulted you in connection with this disability/incapacity:**

_____

5. **Dates of all consultations in connection with this disability/incapacity:**

_____

_____

_____

_____

_____

6. **Please provide the diagnosis(es) applicable to this claimant and <u>how</u> it disables or incapacitates the claimant:**

_____

_____

_____

_____

7. **Please detail the onset and history of the claimant's illness and / or injury:**

_____

_____

_____

**8. Please indicate whether the claimant's incapacity was occasioned by any of the following**

| | |
|---|---|
| ▪ **Ill health or Disease** | |
| ▪ **Occupational Disease** | |
| ▪ **Injury / accident on duty** | |
| ▪ **Injury / accident off duty** | |
| ▪ **Violence off duty** | |
| ▪ **Substance or alcohol misuse** | |
| ▪ **Self inflicted injury** | |

**9. Is the claimant's disability/incapacity as a result of an Injury on Duty or an Occupational Disease? (Yes / No)**

_____

**If yes, have you submitted the relevant forms to the offices of the Compensation Commissioner for Occupational Injuries and Diseases? (Yes / No)**

_____

**If not, why not**?

_____

_____

**10. Please give details of *all* your consultations with the claimant over the past year**

| Date | Complaint | Treatment | Response |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**11. Please provide details of other Medical Practitioners or Allied Professionals consulted, including any Hospital admissions over the past five years.**

| Date | Medical Practitioner and Hospital | Specialty | Treatment / Surgery |
|---|---|---|---|
| | | | |
| | | | |
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**12. Describe fully the nature and extent of the *functional impairments*, which results in the claimant's apparent inability to perform his/her normal duties:**

_____

_____

_____

_____

_____

_____

**13. What were the presenting symptoms and when did they first appear?**

_____

_____

_____

_____

_____

14. **Please detail any concurrent conditions and how they are impacting on the claimant's incapacity:**

_____

_____

_____

_____

_____

15. **Please detail the objective findings such as blood tests, x-rays, ECG's, Echocardiography findings, histology results etc. (PLEASE INCLUDE COPIES OF ALL AVAILABLE REPORTS):**

_____

_____

_____

_____

_____

16. **Detail all treatments, including the pharmacological treatment and dosages, rehabilitation, counseling etc. and how successful they have been:**

_____

_____

_____

_____

_____

**17. If no treatment has been initiated do you envisage any form of intervention (e.g. pharmacological or surgical) being beneficial in diminishing the degree of functional impairment?**

_____

_____

_____

_____

_____

**18. If applicable, please detail any complications or side effects of any treatment instituted:**

_____

_____

_____

_____

_____

**19. Please comment on the claimant's response and compliance to all treatment initiated:**

_____

_____

_____

_____

_____

_____

**20. Do you consider the claimant's treatment to be optimised? (Yes / No) _____**
**If no, please comment and indicate what further treatment you believe could be beneficial**

_____

_____

_____

_____

_____

_____

**21. Do you believe the claimant should undergo further investigations?**
**Please Comment:**

_____

_____

_____

_____

_____

**22. Do you believe the claimant would benefit from any further surgical procedure?**
**Please comment:**

_____

_____

_____

_____

_____

_____

**23. Do you believe the claimant would benefit from any rehabilitation?**
**Please comment:**

_____

_____

_____

_____

_____

_____

**24. What is the claimant's overall prognosis in respect of life expectancy?**

_____

_____

_____

_____

**25. What is the claimant's occupational prognosis?**
**Please detail:**

_____

_____

_____

_____

_____

**26. How long do you estimate the present degree of incapacity will last? (e.g. temporary or permanent) In the case of temporary incapacity, please indicate an approximate time period:**

_____

_____

_____

_____

_____

**27. In your opinion, what is the likelihood of any improvement in the claimant's condition on a scale of 1 to 10 (where 1 is no improvement and 10 is complete recovery).**
**Please detail the extent and nature of estimated recovery:**

_____

_____

_____

**28. Does the claimant's work duties and / or environment aggravate his illness or injury?**

**(Yes /No)** _____

**Please detail:**

_____

_____

_____

_____

**29. List the medical problems affecting the claimant's work performance in order of priority/ severity and give a brief description of the impact each problem has on specific work requirements (with (a) being the most severe and (f) the least severe)**

**a.**_____

_____

**b.**_____

_____

**c.**_____

_____

**d.**_____

_____

**e.**_____

_____

**30. As far as you are aware, when was the claimant last able to perform his / her job?**

_____

**31. If the claimant is temporarily unable to perform his / her own occupational duties, when do you expect the patient to be able to perform such duties?**

_____

**Please specify if this is only some duties or all duties:**

_____

_____

_____

_____

**32. If the claimant is unable to perform his / her own occupational duties, please suggest what you would consider suitable types of work he / she may be capable of performing:**

_____

_____

_____

**33. IMPACT OF ILLNESS OR INJURY**

**In order that we may assess the claimant's functional ability to perform various occupations and not only his current occupation, it would be appreciated if you could indicate to what extent the claimant is likely to be able to perform each of the following activities. If possible these abilities should be measured relative to what they would have been without the illnesses or injuries under consideration, i.e ignore factors such as intelligence or natural abilities of the claimant.**

| **Activity, task or function** | **Relative ability to attend to activity – e.g. impossible, possible subject to great / some pain / discomfort, dangerous to himself / others, no limitation etc** | **Is this ability likely to improve, deteriorate or remain constant.** | **If possible, please estimate the time frame over which any change may take place.** |
|---|---|---|---|
| Clerical or administrative work (sedentary occupations) | | | |
| Thinking clearly and making decisions | | | |
| Interacting with people in the workplace – customers colleagues etc | | | |
| Supervising other staff | | | |
| Walking (non-strenuous) over level ground | | | |
| Walking (strenuous) over uneven ground, climbing (e.g into roofs of houses) working in cramped conditions | | | |
| Operating of heavy machinery | | | |
| Operating of light machinery | | | |
| Carrying heavy weights | | | |

| Activity, task or function | Relative ability to attend to activity – e.g. impossible, possible subject to great / some pain / discomfort, dangerous to himself / others, no limitation etc | Is this ability likely to improve, deteriorate or remain constant. | If possible, please estimate the time frame over which any change may take place. |
|---|---|---|---|
| Carrying light weights - including for example mail deliveries | | | |
| Driving a light motor vehicle | | | |
| Driving a heavy motor vehicle, including graders | | | |
| Manual labour, digging holes, pushing barrows etc | | | |
| Working in a dusty environment, e.g. a mill or factories working with fibrous material | | | |
| Performing limited work in a sheltered environment- e.g. weaving baskets | | | |
| Teaching | | | |
| Policing | | | |
| Guarding | | | |

**34. Does the claimant use any assistive devices? (Yes / No):_____**

**If yes, please elaborate:**

_____

_____

_____

**If no, could the claimant benefit from any assistive device? (Yes /No):_____**

**Please Specify:**

_____

_____

**35. Please comment on the claimant's general mobility:**

_____

_____

_____

_____

_____

**36. Please add any general comments in respect of this claimant's state of health that will assist the multi - disciplinary team in assessing the validity of this disability/incapacity claim:**

_____

_____

_____

_____

**I HEREBY DECLARE AND WARRANT THAT THE INFORMATION GIVEN ABOVE IS FACTUAL, TRUE AND CORRECT AND THAT NO MATERIAL INFORMATION HAS BEEN WITHELD OR ANY RELEVANT CIRCUMSTANCES OMITTED.**

**SIGNED AT _____ON _____20 _____**

**DOCTOR'S SIGNATURE : _____**

**DOCTOR'S NAME :**

_____

**(PLEASE PRINT CLEARLY)**

**DOCTOR'S SPECIALITY : _____**

**DOCTOR'S ADDRESS :**

_____

**(PLEASE PRINT CLEARLY)**

_____

_____

**DOCTOR'S TELEPHONE NO: (CODE)_____(NO)_____**

**DOCTOR'S CELLULAR TELEPHONE NO: _____**

**DOCTOR'S FAX NO: (CODE)_____(NO)_____**

**DOCTOR'S E-MAIL ADDRESS: _____**