Ref No 206

Medical Progress Form

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

For

SOUTH AFRICAN LOCAL AUTHORITIES PENSION FUND MEMBERS

NOTE: The completed Medical Progress Form to be forwarded by the Claimant via registered post to:

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

GLA Death, Family Funeral, Disability: Monthly Income and Accidental Hospitalization Benefits administered by Prosperity Management *Africa* (Pty) Ltd

IMPORTANT NOTES AND CHECKLIST:

Please note that following payment of a Disability: Monthly Income Benefit for a period of 24 months for which the Claimant was assessed as being Disabled to perform his/her own occupation, the Claimant is again being reviewed to assess whether he/she can perform any other reasonable occupation within the Open Labour Market.

- **The cost of this report is for the Claimant's account;**
- **All answers to be in print;**
- **For any queries please contact the Soma Help Desk on (021) 671 1977.**

CHECKLIST **DOCUMENTATION REQUIRED BY SOMA**	Attach all ***new and up to date*** available supporting Medical Reports, X-rays, Special Investigations etc, to prove Total and Permanent disability for **ANY** occupation.	

CLAIMANT DETAILS

Claimant's Full Name (Please print)	
Name of Employer	
Identity Number	

PLEASE INDICATE

1. **Are you the Claimant's usual Medical Specialist / General Practitioner? If so, please confirm your speciality.**

   _____

2. **If not, why have *you* been requested to complete this *Progress 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. **Please provide the *current diagnosis(es)* and concurrent conditions applicable to this Claimant and whether it / they continues to Totally and Permanently Disable or incapacitate the Claimant for ANY occupation within the Open Labour Market:**

   _____
   _____
   _____
   _____

6. Please provide the onset and history of the Claimant's illness and / or injury and detail its progression over the past two (2) years:

_____
_____
_____
_____

7. Please give details of *all* your consultations and treatment with the Claimant over the past two (2) years

Date	Complaint	Treatment	Response

8. Please provide details of other Medical Practitioners or Allied Professionals consulted, including any Hospital admissions over the past two (2) years.

Date	Medical Practitioner and Hospital	Specialty	Treatment / Surgery

9. Details of last clinical examination (including weight, height, blood pressure, and systems report etc:

_____
_____
_____
_____

10. Describe fully the nature and extent of the Claimants *continued functional impairments*, if any.

_____
_____

_____
_____
_____

11. What were the Claimant's *initial* presenting symptoms and are they *still present*? If so, please elaborate and provide full details

_____
_____
_____

12. Please detail the objective findings such as blood tests, x-rays, ECGs, Echocardiography findings, histology results etc. that have been conducted in the past two (2) years (PLEASE INCLUDE COPIES OF ALL AVAILABLE REPORTS):

_____
_____
_____
_____

13. Detail all *current ongoing treatments*, including pharmacological treatment and dosages, rehabilitation, counseling etc. and *how successful these interventions have been in reducing the functional impairments*:

_____
_____
_____
_____

14. If no treatment has been initiated do you envisage any form of intervention (pharmacological, surgical or rehabilitative) being beneficial in diminishing the degree of current functional impairment?

_____
_____
_____

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

_____
_____

16. Please comment in detail on the Claimant's response and compliance to all treatment initiated:

_____
_____
_____
_____

17. 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

_____
_____
_____
_____

18. What is the Claimant's overall prognosis in respect of life expectancy?

_____

19. What is the Claimant's future occupational prognosis?

_____

_____

_____

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

_____

_____

21. In the event that the Claimant is currently still incapacitated to any degree, 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:

_____

_____

22. If the Claimant is still unable to perform his / her own last occupational duties, please suggest what you would consider suitable types of work he / she may currently be capable of performing:

_____

_____

_____

23. Does the Claimant currently use any assistive devices? (Yes / No):_____
If yes, please elaborate:

_____

_____

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

_____

_____

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

_____

_____

25. Do you think that the Claimant is Totally and Permanently Disabled for ANY occupation?
If yes, or no, please elaborate

_____

_____

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: _____

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 CONTINUED DISABILITY / INCAPACITY BENEFIT PAYMENT.