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CONFIDENTIAL DOCTOR'S REPORT

To be completed by the member's treating doctor. Please answer each question in full. Do no use a dash, correction fluid or leave blank. Where a choice is given, please tick the appropriate box. Please do not show the member your report and return the report directly to Liberty.

PATIENT DETAILS

A) Name of Patient: _____

B) Patient ID number: | | | | | | | | | | | | | |

C) Scheme number: _____

D) Scheme name: _____

E) Employer name: _____

F) Cell number: _____

HISTORY

A) Are you treating the patient for the impairment that gave rise to this claim? ☐YES ☐NO

B) Date of first consultation: _____

C) Dates of consultations for the past six months:

D) What is the patient's diagnosis? _____

E) When did the symptoms first appear? _____

F) Is the patient still working? ☐YES ☐NO

If "NO" when did he/she stop working? _____

G) Has the patient 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

_____

_____

H) Do you have results of any special investigations e.g. X-rays, ECG's, Scans, etc.? ☐YES ☐NO

If "YES" (Kindly submit copies of these as well as copies of any other reports on file relating to this impairment)

I) Has the patient ever been referred to any other medical practitioner or are you aware of any other medical practitioner, specialist, etc. who has been consulted by the patient for this or any other conditions? ☐YES ☐NO

If "YES" please provide names and dates

_____

_____

_____

Please note that in the event of any modification or variation of this standard form Libert will regard this form as being invalid and of no force and effect. **Do not sign blank or incomplete forms.**

J) Has the patient ever suffered from any complications? ☐YES ☐NO

If "YES" please provide details

K) Have any of the following contributed to the patient's present condition?

Abuse of alcohol or drugs ☐YES ☐NO

Attempted suicide ☐YES ☐NO

Elective abortion ☐YES ☐NO

If "YES" to any of the above, please provide details

L) Has the patient ever been tested for or received medical advice or treatment in connection with any sexually transmitted diseases, including Hepatitis B or an AIDS related condition? ☐YES ☐NO

M) Are you aware of any family history, which may have predisposed the patient to this condition?

PATIENT'S PRESENT CONDITION

A) What are the patient's symptoms?

B) What are the objective clinical findings upon examination?

C) Patient's height: _____ (cm) Patient's weight: _____ (kg)

D) What is the patient's prognosis? _____

E) List all treatment the patient is currently receiving or has previously received for this condition and what the response to treatment has been?

F) Is the patient compliant regarding the treatment? ☐YES ☐NO

G) Is the patient still under your care? ☐YES ☐NO

H) Is any further treatment available? ☐YES ☐NO

If "YES", please specify the treatment plan

FUNCTIONAL ABILITY

What effect has the condition had on the patient's ability to function normally?

A) Can the patient climb stairs? ☐YES ☐NO

B) Can the patient write? ☐YES ☐NO

C) Can the patient lift objects ± 2kg? ☐YES ☐NO

D) Can the patient drive? ☐YES ☐NO

E) Can the patient travel? ☐YES ☐NO

F) Can the patient take care of their personal hygiene? ☐YES ☐NO

G) Has the patient's mental ability been affected? ☐YES ☐NO

If "YES" is the patient able to handle his/her financial affairs?

_____

_____

_____

H) Can the patient do shopping? ☐YES ☐NO

I) For what period of time can the patient sit? _____

J) For what period of time can the patient stand? _____

K) For what period of time can the patient walk? _____

L) Can the patient bend? ☐YES ☐NO

M) Can the patient squat? ☐YES ☐NO

N) Please describe any further functional impairments:

_____

_____

_____

_____

DECLARATION

I certify that I have personally attended to the patient and that, to the best of my knowledge, the above statements are correct and complete.

Signed at _____ Date _____

Name (please print): _____

Qualifications: _____

Address: _____

Telephone no: _____ Fax no: _____

Signature _____

SAMDC number: _____ Practice number: _____

NOTE:
a) The member is responsible for settling medical expenses incurred in initially substantiating any claim.
b) In terms of the Promotion of Access to Information Act, by completing and returning this report to us, you confirm that you are aware of and that you consent to the information being released to the client / patient in the event of the appropriate request in terms of any law, including the Promotion of Access to Information Act No.2 of 2000.