momentum

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 claimant'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 claimant, we would appreciate your speedy assistance with this matter.Thorough completion of this form will enable us to finalize 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 +264 61 234 851 or emailed to ebnamdisability@momentum.com.na or posted to PO Box 3785, Windhoek 9000, attention Momentum Employee Benefits 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

Namibian ID: Yes | No — ID/Passport No.

Passport country of origin

Male | Female

3. Medical practitioner's details

Name of doctor

Qualifications/speciality

Hospital / Practice name

Practice number

Address

Postal code:

Telephone - work — Fax

Email

4. Consultation history

Date of your first ever consultation with the member D D - M M - 2 0 Y Y

Date of your first consultation with regard to the current symptomology D D - M M - 2 0 Y Y

Date of your last consultation with the member (prior to current consultation) D D - M M - 2 0 Y Y

Date of current consultation and examination D D - M M - 2 0 Y Y

How frequently do you see the member (eg 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

D D - M M - 2 0 Y Y _____

D D - M M - 2 0 Y Y _____

D D - M M - 2 0 Y Y _____

D D - M M - 2 0 Y Y _____

c. For psychiatric claims, please provide the DSM IV 5 Axis diagnosis

Axis I	
Axis II	
Axis III	
Axis IV	
Axis V	

d. Please provide a brief history of the claimant'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 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 (eg 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 claimant'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 (eg 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 eg 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 claimant'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 claimant 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 claimant's ability to perform activities and daily living and self care tasks. Advise what is and what is not possible

Comment on the claimant's current daily activity profile ie how does the claimant 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 - 2 0 Y Y

Date

Options to sign the form:

1. Print out the form, sign and scan it and send it back via email to ebnamdisability@momentum.com.na , fax it to Fax +26 (4)61 234 851 or posted to PO Box 3785, Windhoek 9000, attention Momentum Employee Benefits disability claims.
2. Place your scanned signature in the signature block.
   - Store your scanned signature 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.

When you want to print the form to complete by hand you can turn off the field highlights by selecting the "highlight existing fields" on the top right hand corner of your screen.

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