CERTIFICATE NO:

MEDICAL REPORT FOR DEATH CLAIM (FOR PRACTITIONER)

DECEASED PERSONAL DETAILS

Full name: ______________________ ID number: ______________________

Address: ______________________

Date of death: ______________________ Place of death: ______________________

Hospital/Patient/File number: ______________________ Medical aid detail: ______________________

Medical Practitioner's detail

Name of Doctor: ______________________ Practice number: ______________________

Address: ______________________

Telephone number: ______________________ Fax: ______________________

Email ______________________ Qualification: ______________________

When did deceased first consult you? ______________________ DD/MM/YYYY

When was the last time you consulted the deceased prior to death: ______________________ DD/MM/YYYY

Details of death:

What was the immediate cause of death:

____

____

When was the date of onset of the immediate condition and when was the diagnosis made:

____

____

Sequentially list conditions if any, leading to immediate cause

____

____

Enter underlying cause (Disease or injury that initiated events resulting in death

____

____

If the cause of death was due to unnatural causes please provide a description and details of the event:

____

____

Were there any contributing factors to the death, including any previous illnesses, family history, injuries, trauma, and personal habits including the use of narcotics or alcohol and hazardous pursuits?

____

____

____

Were you the person who notified the death? If no, please provide the name of the relevant person:

____

Was an autopsy/postmortem performed? (Please provide name of forensic laboratory/mortuary where it was performed or enclose copy of report)

____

Deceased consultation history:

Please provide details of all other consultations with the deceased, whether or not the reason for consultation was related to the cause:

Date:____________________ Reason for consultation:______________________ Diagnosis & treatment:___________________________

Date:____________________ Reason for consultation:______________________ Diagnosis & treatment:___________________________

Date:____________________ Reason for consultation:______________________ Diagnosis & treatment:___________________________

Date:____________________ Reason for consultation:______________________ Diagnosis & treatment:___________________________

Date:____________________ Reason for consultation:______________________ Diagnosis & treatment:___________________________

Date:____________________ Reason for consultation:______________________ Diagnosis & treatment:___________________________

Date:____________________ Reason for consultation:______________________ Diagnosis & treatment:___________________________

(if not enough space please attach a detail consultation history on a official letter head)

Did the deceased ever test positive for HIV antibodies?

What was the date of the diagnosis? Please enclose copy of the test results

YES	NO

DD/MM/YYYY

Please provide details of any other Practitioner's, Specialists or hospitals to whom the deceased had been referred, either in relation to the cause of death or for any other condition. Please include copies of all available Specialist reports.

____

____

____

Additional information:

Is there any other information which in you opinion may assist us in assessing this claim:

____

____

____

____

____

____

____

____

Declaration:

I hereby declare that I have been the deceased attending medical doctor and warrant that the content of this report is true and correct to the best of my knowledge, and that no information which may influence the outcome of this claim has been withheld or omitted.

Doctor's signature

Signed on DD/MM/YYYY

Practice official company stamp

(Please send this form to: Fax: 086 218 9202 or Email: claims@nttgroup.co.za or PO Box 35302, Menlopark, 0102)