Guardrisk INSURANCE
INNOVATIVE RISK SOLUTIONS

CERTIFICATE NO:

MEDICAL REPORT FOR DISABILITY CLAIM (FOR PRACTITIONER)

PATIENT PERSONAL DETAILS

Full name: _____ ID number: _____

Address: _____

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

Medical Practitioner's detail

Name of Doctor: _____ Practice number: _____

Address: _____

Telephone number: _____ Fax: _____

Email _____ Qualification: _____

When did the patient first consult you? _____
DD/MM/YYYY

Details of disability

Type of disability:

When were you first consulted about this injury or illness?

If disability is due to accident, what injuries were sustained?

If disability is due to an illness, please describe fully the nature and extent of this illness:

Is the patient's disability due to illness or accident alone or is there some other cause in addition to the illness or accident that contributed to the disability?

Do you know of any hereditary disease in the patient's family?

Do you know of any factors regarding past or present health, habits or lifestyle witch may have contributed to the occurrence of the illness/accident, or which may be likely to retard recovery? If so, please give detail

Can you certify that the patient is or has been totally unable to follow his/her occupation YES or NO

If so, when did he/she first become unable to follow his/her occupation? _____

Is the patient able to attend to a portion of his/her occupation? YES or NO

If so, when did he/she become able to do so? _____

When did, or will the patient become able to resume his/her occupation? _____

Please give any further information which you think may be of help to us in considering the patients claim for disability benefit:

Declaration:

I hereby declare that I have been the patient's 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)*