CERTIFICATE NO:

MEDICAL REPORT FOR DREAD DISEASE (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 disease:

Type of illness (please tick)

Heart attack_____ Stroke_____ Cancer_____ Coronary Artery disease_____

Renal failure_____ Transplant_____ Paraplegia_____ Coma_____

Serious burns_____

When did the patient first become aware of the symptoms or what was the date of incident?

_____

_____

When was medical advise sought?

_____

Has this patient suffered from this disease in the past? If yes, please give detail.

_____

_____

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 any health problems?
Please supply details:

_____

_____

_____

Full description of dread disease:

Please give full detail of all operations and treatments the patient had relating to this dread disease:

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)*