momentum

FundsAtWork Namibia
Confidential medical report for a disability claim

Member number

Please fill in this form in the fields provided. Use the tab key to move from one field to the next.

Dear Doctor
This report is in respect of a disability claim that has been submitted by one of your patients. Momentum will not be liable for any cost in connection with this report.

To protect the privacy of the member, please do not show the member your report. The report should be returned directly to Momentum FundsAtWork at PO Box 79 Windhoek 9000 or emailed to fundsatworknamibia@momentum.co.na.

Thank you for your assistance.

Section 1: Scheme details

Name of scheme

Scheme code

Name of employer

Section 2: Member details

Title | Initial/s

First name

Surname

Date of birth D D - M M - Y Y Y Y

National identity document Yes | No | Identity / Passport number

Passport country of origin

Residential address

Postal Code

Postal address

Postal Code

Telephone - work | Fax

Telephone - home | Cellphone number

Email address

Tax Office | Tax number

Section 3: Medical practitioner's details

Name

Qualifications/speciality

Postal address

Postal Code

Telephone - work | Fax

Practice number

Section 4: Consultation history

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

Date of your first consultation with regard to the current symptoms D D - M M - Y Y Y Y

Date of your last consultation with the member D D - M M - Y Y Y Y

Member number

Section 5: Medical references

Please give the details of any other practitioners, specialists or hospitals that the member has been referred to.
Please include copies of all available specialist reports.

Name of practitioner/hospital			
Speciality			
Postal address			
Complaints referred for			

Section 6: Medical history

Please give a full history, including the following:

Symptoms

Date and diagnosis

D D - M M - Y Y Y Y

D D - M M - Y Y Y Y

D D - M M - Y Y Y Y

D D - M M - Y Y Y Y

Clinical details indicating severity and permanence

Relevant test results (eg lung function readings, X-ray or scan results)

Treatment and response

Rehabilitation

Comments on compliance

Member number

Section 6: Medical history (continued)

Current major complaint/s

Section 7: Results of the most recent medical examination

Date of examination D D - M M - Y Y Y Y

Please give full clinical details of the examination, including height, weight and blood pressure readings. Please include details of any limitations evident at the examination (eg joint limitations, visual acuities)

Height (cm)

Weight (kg)

Blood pressure

Visual acuity

Section 8: Prognosis

What are the chances of recovery? Good Fair Nil

Are any residual problems likely?
Please specify

Section 9: Function abilities

Please comment on the member's 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 & 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							

Activity	**Current limitations**				**Expected future ability**		
	No limitations	Partial limitations	Impossible	Danger to self or others	Improve	Remain constant	Deteriorate
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							

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 attach copies of any correspondence received from any practitioners, specialists or hospitals in respect of the member and clinical investigations.

Member number

Section 10: 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.

Member's signature

Date D D - M M - 2 0 Y Y

Completed form together with supporting documents to be faxed to +264 61 299 7537 or emailed to fundsatworknamibia@momentum.co.na

When you sign this form by inserting a digital signature it confirms that the information provided is true and correct.

Options to sign the form:

1. Print out the form, sign and scan it and send it back via email to fundsatworknamibia@momentum.co.za or fax it to +264 61 234 851.
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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