



# KZN

MUNICIPAL PENSION FUND  
Together We Grow Your Wealth

## Disability Claim – Confidential Medical Report

### Part 3: Treating specialist to complete this form

The medical information requested in this form is in support of a claim for disability benefits provided by the member'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 member, we would appreciate your speedy assistance with this matter. Thorough completion of this form will enable us to finalize the claim without unnecessary delays. As this report is in support of a claim application, any cost in connection with this report will be for the account of the member. **The Fund will not be liable for any cost in connection with completing this report.**

Please ensure that copies of all clinical test results and specialist reports etc are attached.

Completed form to be sent to the relevant HRO from the Municipality or sent directly to **KZN Municipal Pension Fund, 16 Floor, 22 Dorothy Nyembe Street, The Marine Building, Durban Central, 4001, Contact No. 0313229001**

Date(s) of consultation	
Name of Employee	
Diagnosis	
History of the current condition including any hospital and admissions	
Current clinical examination	

### 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
Date of current consultation and examination	D	D	-	M	M	-	Y	Y	Y	Y

## Medical references

Please give the detail of any other practitioners, specialists or hospitals that the member has been referred to.

Name of practitioner/hospital			
Specially			
Postal address			
Tel no.			
Complaints referred for			
Date referred			

## Details of medical condition

Please give details of the illness/accidents for which you have attended since the member was referred to you?

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Diagnosis and Date of diagnosis

Date of Diagnosis										Diagnosis	Code
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		

For psychiatric claims, please detail the member's diagnosis using either the DSM IV or DMS V criteria


Please provide a brief history of the member's condition

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Please provide details of any current or previous substance abuse, if applicable.

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**Details of medical condition (continued)**

Corrected visualacuity

Limitations evident at the examination (eg range of movement, mental state etc)

Current major complaint/s as per the member

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.

Describe fully the member's current symptoms

Describe in detail the nature and extent of the member's impairment

Clinical details indicating severity and permanence

Provide the outcome of any other specialist consultations, if applicable. Please enclose copies of available specialist medical reports

Give dates and outcome of any tests/investigations done to diagnose/confirm the member's condition. Please enclose copies of any reports/investigations done

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For psychiatric claims, please provide the results of any bedside cognitive assessments (eg but not limited to MMSE)

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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

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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.

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Please provide details of any previous or current hospital admissions. Kindly indicate the dates of admission and discharge and reason for admission.

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Please comment on any occupational therapy assessments, functional assessments or rehabilitation received and the outcome thereof.

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Please comment on the effectiveness of treatment /member's response to treatment.

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Please advise regarding planned future treatment. Refer to medication, surgery, rehabilitation etc and provide dates

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Brief details of member's current occupation (job title and duties).

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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
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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?

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What functions can the member still perform?

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When is the member expected to be able to return to work

D	D	-	M	M	-	Y	Y	Y	Y
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Has the member made any requests for or been offered reasonable accommodation at work? Please provide details

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## 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 decision							
Interacting with others							
Supervising others							
Walking on level terrain							
Walking 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.

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Please comment on the member's ability to perform activities and daily living and self care tasks. Advise what is and what is not possible

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Comment on the member's current daily activity profile ie how does the member spend his/her time at present?

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### Declaration

I hereby declare that I have personally and attended to the member and that the contents of this report are true and correct.

					D	D	-	M	M	-	Y	Y	Y	Y
<b>Signature of Medical Practitioner</b>					<b>Date</b>									