



**MEDICAL REPORT**

**TO BE COMPLETED BY YOUR MEDICAL PRACTITIONER**

Name of Claimant/Patient \_\_\_\_\_

1. Medical Practitioner's Full Name \_\_\_\_\_

2. Phone No. (hm) \_\_\_\_\_

Phone No. (wk) \_\_\_\_\_

Fax \_\_\_\_\_

Address \_\_\_\_\_

Suburb \_\_\_\_\_

City \_\_\_\_\_

Postcode \_\_\_\_\_

3. What is your patient's occupation, business or profession? \_\_\_\_\_

4. Are you the patient's usual medical practitioner?  Yes  No

If so, how long has he/she been a patient? \_\_\_\_\_

5. State the nature and extent of the injuries or illness

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. What do you believe is the cause of the injuries or illness

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. Please give details of the treatment given

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8. Is the patient (to your knowledge) complying with your treatment instructions?  Yes  No

9. On what date did you first attend the patient in connection with this condition? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

10. To your knowledge, has the patient previously suffered from this condition?  Yes  No

If Yes, please provide full details including when the condition was first diagnosed

11. Do you consider this injury or illness is terminal or will result in permanent disablement?  Yes  No

If Yes, please give details

12. Has the patient been referred to a specialist or do you intend to refer the patient to a specialist?  Yes  No

Name and address of specialist (if applicable) \_\_\_\_\_

13. To your knowledge, was the injury self-inflicted? (if applicable)  Yes  No

14. Is this condition directly or indirectly related to AIDS or an AIDS related condition, alcohol, drugs or poison?  Yes  No

Please give details

15. Is the Claimant suffering from any other conditions (additional to that described in question 6 above)?  Yes  No

If so, please state the nature of the condition and to what extent recovery may be affected

16. Please confirm the patient has been unable to attend work from \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

17. When do you expect the patient will resume work \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Part of their work \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Full time duties \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

18. General remarks

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Medical Practitioner \_\_\_\_\_

Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_