









**4. Current Medical Status**

**Current major complaints**


**Please provide a brief history of the claimant's condition**


**Describe fully the claimant's current symptoms**


**Please give full clinical and objective evidence for example general look, height, weight, blood pressure, heart sounds about the claimant's current health, symptoms and impairments**


**Current major complaints**


**Please provide a brief history of the claimant's condition**


**Describe fully the claimant's current symptoms**


## 4. Current Medical Status (Continued)

Corrected visual acuity


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


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 test/ investigations done to diagnose/quantify the member's condition. Please enclose copies of any reports/ investigations done.


For psychiatric claims, please provide the DSM IV 5 Axis diagnosis

<b>Axis I</b>	
<b>Axis II</b>	
<b>Axis III</b>	
<b>Axis IV</b>	
<b>Axis V</b>	

## 4. Current Medical Status (Continued)

For psychiatric claims, please provide details and comment on any family history of mental illness.


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.


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


### Treatment and Rehabilitation:

Please describe the previous and current treatment that the member has/is receiving for his/her condition. Please include names, dosage and dates/duration of all medication.

Medicine													Dosage							
Start Date				End Date				Period												
Y	Y	Y	Y	M	M	D	D	-	Y	Y	Y	Y	M	M	D	D	Current	<input type="checkbox"/>	Previous	<input type="checkbox"/>

Medicine													Dosage							
Start Date				End Date				Period												
Y	Y	Y	Y	M	M	D	D	-	Y	Y	Y	Y	M	M	D	D	Current	<input type="checkbox"/>	Previous	<input type="checkbox"/>

Medicine													Dosage							
Start Date				End Date				Period												
Y	Y	Y	Y	M	M	D	D	-	Y	Y	Y	Y	M	M	D	D	Current	<input type="checkbox"/>	Previous	<input type="checkbox"/>

## 4. Current Medical Status (Continued)

Medicine														Dosage						
Start Date				End Date				Period												
Y	Y	Y	Y	M	M	D	D	-	Y	Y	Y	Y	M	M	D	D	Current	<input type="checkbox"/>	Previous	<input type="checkbox"/>

Medicine														Dosage						
Start Date				End Date				Period												
Y	Y	Y	Y	M	M	D	D	-	Y	Y	Y	Y	M	M	D	D	Current	<input type="checkbox"/>	Previous	<input type="checkbox"/>

Medicine														Dosage						
Start Date				End Date				Period												
Y	Y	Y	Y	M	M	D	D	-	Y	Y	Y	Y	M	M	D	D	Current	<input type="checkbox"/>	Previous	<input type="checkbox"/>

What is the success rate or effectiveness of the claimant's current treatment?

Are there any other treatment or rehabilitation that the claimant has received or is currently receiving for example: physiotherapy, occupational therapy, psychotherapy etc?

Is there any other treatment, which the claimant could benefit from, but cannot afford or does not have access to? Please comment

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



## 4. Current Medical Status (Continued)

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

Date of Admission	Date of Discharge																
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Date of Admission	Date of Discharge																
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Y	Y	Y	Y	M	M	D	D										
Y	Y	Y	Y	M	M	D	D										
Reason for Admission																	

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

#### 4. Current Medical Status (Continued)

In your opinion, is the condition one that would benefit from any form of active rehabilitation?

Yes

No

If Yes, please provide suggestions/details of rehabilitation that would be of benefit.


In your opinion is the treatment optimal?

Yes

No

If No, suggest possible alternative therapy, medication, rehabilitation or surgery that may be attempted to maximise management.


#### Compliance to treatment:

Comment on the member's compliance with treatment (medication, therapy/ rehabilitation, follow up consultations etc.). If not compliant, please advise why not.


Has the condition stabilised or regresses since onset? Please provide substantiating details.


#### Prognosis:

What are the chances of recovery for example good, fair, poor and nil


Provide the member's short term and long term prognosis with supporting reasons.


## 4. Current Medical Status (Continued)

In your experience, can you give an indication of the expected recovery period necessary for this member and his/her condition?


Are any residual problems likely?

Yes

No

If Yes, please give details:


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


In your opinion what was the last date that the member was actively able to work?

Y	Y	Y	Y	M	M	D	D
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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?


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

Y	Y	Y	Y	M	M	D	D
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### Functional Limitations or Abilities:

Please comment on the claimant's current and expected future ability to carry out specified activities in the below table:

Activity	Current Limitations				Expected Future Ability		
	No Limitation	Partial Limitation	Impossible	Danger to self or others	Improve	Remain Constant	Deteriorate
Seated/Sedentary Tasks							
Clerical/Administrative tasks							
Management and making decisions							
Interacting with others							

## 4. Current Medical Status (Continued)

Please comment on the claimant's current and expected future ability to carry out specified activities in the below table:

Activity	Current Limitations				Expected Future Ability		
	No Limitation	Partial Limitation	Impossible	Danger to self or others	Improve	Remain Constant	Deteriorate
Supervising others							
Walking on level terrain							
Walking on uneven terrain							
Climbing							
Kneeling							
Bending							
Standing							
Lifting							
Pushing and Pulling							
Operating light machinery							
Operating heavy machinery							
Working with light weights							
Working with heavy weights							
Light Manual Labour							
Heavy Manual Labour							
Driving							
Use of both hands							
Use of fine co-ordination							
Work in cramped conditions							

## 4. Current Medical Status (Continued)

Please comment on the claimant's current and expected future ability to carry out specified activities in the below table:

Activity	Current Limitations				Expected Future Ability		
	No Limitation	Partial Limitation	Impossible	Danger to self or others	Improve	Remain Constant	Deteriorate
Work in dusty environment							
Work in fume environment							

Please provide any general comments which may clarify the responses in the table. If improvements is expected, please indicate the period within which that improvement is anticipated.


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


Comment on the claimant's current daily activity profile i.e. how does the claimant spend his/her time at present?


