



Guidelines for a confidential medical report

Important: The examination and compiling of a medical report must be done by the patient's treating specialist. Only if there is no treating specialist attending to the insured, may a general practitioner complete the report.

Dear Doctor,

Sanlam is in the process of assessing the extent of the patient's disabilities, in view of a claim for disability benefits. To assist us in making a justified decision, we require a report regarding the functional impairment of the patient.

Please complete the attached Confidential Medical Report form. If you choose to submit a typed report, then the guidelines below apply.

Please note that the patient's identity needs to be established above doubt before proceeding with the examination. Confirm the document/means used to establish the patient's identity, in your report.

Any costs relating to this consultation and medical report is for the patient's account. Should you require additional test / evaluations to establish the patient's functional impairment, the patient will also be responsible for settling these.

Guidelines for a medical report on functional impairment

- Diagnosis (DSM IV/V for psychiatric conditions)
- Date of onset and course of disease
- Severity, perpetual factors, secondary gain
- Current clinical findings. Please provide a detailed description.
- Treatment
 - Treatment modalities
 - Types of medication and dosage
 - Duration of treatment
 - Therapeutic procedures
 - Rehabilitation
 - Hospitalisation
 - Dates of consultations
- Response to treatment and side effects
- Compliance with treatment
- Complications that are permanent
- Special investigations (e.g. ECG, X-rays, scans, blood tests, laboratory test results, etc.)
- Prognosis with optimal treatment
- Influence on lifestyle, activities of daily living and working capability
- Special requirements
 - Cardiovascular: NYHA classification, exercise capacity, stress ECG, ejection fraction, echocardiogram, other
 - Respiratory: dyspnea-grading(ATS), exercise capacity, (METS or VO2 max.) vitalogram pre-and post-inhalation (3 attempts), chest X-ray, single-breath diffusion test (Dco) in cases of interstitial lung disease
 - Orthopaedic: X-ray and stress views, MRI or CAT scans, other (eg. nerve conduction tests)
 - Neurological: MRI, CAT scan results, EKC other
 - Surgery: Surgical report
 - Psychiatric: social functioning, concentration, psychometric tests in cases of cognitive impairment, frequency and dates of consultations
 - Immunocompromised conditions: blood tests, CD4 count and viral load



Confidential Medical Report: Disability

Dear Doctor,

Thank you for your time.

We request your assistance with getting a better understanding of the claimant's medical condition to support his/her claim for disability benefits. Your thorough completion of this document will help to expedite our assessment process.

Please note that the cost of completion of this report is for the policyholder's account.

Kindly return the completed report with copies of all relevant clinical or diagnostic tests results or any additional medical information you have available, to sgdisabilityclaims@sanlam.co.za

Please see the attached Guideline document (page 6).

Scheme and personal details

Name of fund/scheme _____
 Name of employer _____
 Name of insured _____
 Insured's date of birth _____ Identity number _____
 Membership number _____

Medical practitioner information

Full names and surname _____
 Address _____ Postal code _____
 Email address _____
 Qualification: _____
 Practice number _____ Contact telephone number _____

1. Course of illness

Since when has the claimant been your patient? _____ (ddmmccyy)

Most recent examination date _____ (ddmmccyy)

Previous consultations:

Date (ddmmccyy)	Diagnosis	Treatment

When was the diagnosis first made? _____ (ddmmccyy)

When did the symptoms present the first time? _____ (ddmmccyy)

Current complaints from the claimant's point of view:

After consultation, what symptoms does the claimant currently present with? (list all):

What permanent complications of the condition have you identified?

Specialist consultations and special investigations done:

Specialist or investigation done	Date (ddmmccyy)	Result

Very important: If you have any specialist reports/psychiatric reports/special investigations (e.g. X-rays, scans, ECGs, lungfunction tests, histology reports, etc), please supply copies.

Current medical examination:

Weight: _____ Height: _____ BP: _____
Pulse: _____ Cholesterol: _____ Blood glucose: _____

2. Treatment

Current medication

Name/type	Dosage	Duration

Previous medication

Name/type	Dosage	Duration

Other forms of treatment (e.g. physiotherapy, rehabilitation, surgery, ECG or psychotherapy)

Type	Name and contact of doctor/therapist	Period of treatment

Please comment on the claimant's compliance to treatment/medication:

Do you consider this treatment optimal? If not, please elaborate:

3. Prognosis

Please give your opinion on the prognosis:

Since when has the claimant been unable to perform the tasks of his/her regular occupation due to his/her condition?

Will further treatment, rehabilitation or work modification lead to improvement of the claimant's ability to function? Please elaborate.

When, in your view, will the insured be able to resume his/her employment or any part thereof?

Full time _____ Part-time _____

4. Functional impairment

In order to determine the claimant's functional ability to pursue a specific occupation, would you please indicate to what extent he/she can carry out the activities listed in the table below. If possible, these abilities should be weighed relatively as it would have been if he/she did not have the injury/illness. The claimant's age, intelligence or natural capabilities should not be considered.

Activity/task or function	Please describe the claimant's ability to carry out the task e.g. Impossible, possible with much/little pain/discomfort, dangerous to himself/herself/others, no limitations, etc.	Will this capability most likely: improve, worsen or remain constant?	If possible, please estimate period over which change will occur. (weeks/months/years)
Clerical or administrative work (sedentary occupation)			
Concentration			
Memory			
Interaction with others (colleagues, clients, etc.)			
Supervisory work			
Sit continuously for more than an hour			
Sit continuously for less than an hour			
Stand continuously for more than an hour			
Stand continuously for less than an hour			
Walks (minimal effort) on level ground			
Walks(with effort) on uneven ground			
Bend, crouch, kneel, crawl, balance			
Climb steps/ladder			
Handling of heavy objects (more than 10kg)			
Handling of light objects (less than 5kg)			
Handling of heavy machinery			
Handling of light machinery			
Fine manual work (e.g. writing, typing, small electrical repairs)			
Driving of heavy vehicle			
Driving of light vehicle			

Additional questions

5. Claimant's co-operation/motivation (e.g. with regards to medication, smoking, weight loss):

6. Other factors that might influence the insured's ability to work (e.g. alcohol, drug dependence, motivation, social problems, conflict with colleagues at present workplace):

7. Please provide any other information that may assist Sanlam in assessment of this claim:

Signature of medical practitioner _____

Date _____ (ddmmccyy)

Place _____

Please provide practice stamp