SINCEPHETELO MVA FUND

MEDICAL REPORT

a. This report must be completed by the medical practitioner who treated the deceased or injured person for the bodily injuries sustained by him in the occurrence out of which this claim arises or by the superintendent (or his representative) of the hospital in which the deceased or injured person was treated for such bodily injuries.
b. Where blocks are provided for the purpose of a reply to a question place a cross in the appropriate block and if answer is yes, provide appropriate details.
c. Please fill in clients Initials at the bottom of each Medical report page.
d. Please complete the form in **BLOCK LETTERS**.

Full name of accident victim: _____

National ID number: _____

Date first seen after accident: _____

Did you treat him / her at any time before the accident? Yes ☐ No ☐

If yes, give the date and nature of ailment: _____

_____

_____

_____

_____

Are the injuries: Minor ☐ Moderately Severe ☐ Severe ☐

Indicate the parts of the body injured:

Head ☐ Neck ☐ Abdomen ☐ Chest ☐

Back ☐ Upper limbs ☐ Lower limbs ☐ Pelvis ☐

Give full details of injuries and complications: _____

_____

_____

_____

_____

_____

Treatment given to date:_____

_____

_____

_____

_____

Is permanent disability expected? Yes ☐ No ☐

If yes, give details: _____

_____

_____

If no, has his / her condition became stabilized? _____

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Is specialist treatment being given? Yes ☐ No ☐

Give full details of nature and expected duration of any future treatment?

_____
_____
_____
_____
_____
_____
_____

Has injury aggravated any pre-existing pathological condition? Yes ☐ No ☐

Has any pre-existing condition been aggravated by trauma? Yes ☐ No ☐

Effects of trauma? _____
_____
_____
_____

If in employment at date of accident, state when return to employment is expected?

_____

Where there has been a fatal termination, indicate:

a. Date of death _____
b. Cause _____
c. Did any pre-existing pathological condition contribute to death? Yes ☐ No ☐
d. If yes, give full details _____
_____
_____
_____
_____

Please provide any other relevant medical details

_____
_____
_____
_____
_____
_____
_____

Name of medical practitioner: _____
Signature: _____
Qualification: _____
Address:_____
Date:_____