| FIRST MEDICAL REPORT | | | | | | | | | | | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| DETAILS OF INJURED employee | | | | | | | | | | | | | | | | | | | |
| Employee Name: | | | | | | | | | | | | | | | | | | | |
| Date of Birth: / / | | | | Occupation: | | | | | | | | Cell No: | | | | | | | |
| Employer Name: | | | | | | | | | | | | | | | | | | | |
| Date of Accident/Onset of Disease: / / | | | | | | | Date of Consultation: / / | | | | | | | | | | | | |
| RMA Claim No: | | | | | | | Industry No/Company No: | | | | | | | | | | | | |
| DETAILS OF INJURY | | | | | | | | | | | | | | | | | | | |
| Mechanism of injury: | | | | | | | | | | | | | | | | | | | |
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| Detailed clinical description of injuries/disease: | | | | | | | | | | | | | | | | | | | |
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| Are the injuries consistent with the mechanism of the injury? Yes | | | | | | | | |  | No | | | |  | |  | | | |
| ICD10 Codes: |  |  | | |  | | |  |  | | |  | | | | |  | |  |
| Briefly describe any pre-existing condition or disease (if any): | | | | | | | | | | | | | | | | | | | |
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| Treatment: Conservative | |  | X-rays | | |  | | Surgery |  | | Referral | | | |  | | |  | |
| Please give detail: | | | | | | | | | | | | | | | | | | | |
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| If the patient is unfit for work, please specify dates: From / / To / / | | | | | | | | | | | | | | | | | | | |
| Or, please state preliminary estimate of days absent from work: | | | | | | | | | | | | | | | | | | | |
| declaration | | | | | | | | | | | | | | | | | | | |
| I declare that after my examination of the above patient, I am satisfied that the injury is work-related and consistent with the injury sustained. | | | | | | | | | | | | | | | | | | | |
| Surname: | | | | | | | | | | | | | Initials: | | | | | | |
| Email: | | | | | | | | | | | | | Tel: | | | | | | |
| Practice No: | | | | | | | | | | | | | Cell No: | | | | | | |
| Address: | | | | | | | | | | | | | | | | | | | |
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|  | | | | | | | | | | | | | Code: | | | | | | |
| Signature: | | | | | | | | | | | | | Date: / / | | | | | | |