| final MEDICAL REPORT |
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| DETAILS OF INJURED employee |
| Name of Employee: |
| Date of Birth: / /  | Occupation: | Cell No: |
| Name of Employer: | Date of Accident/Onset of Disease: / /  |
| RMA Claim No: | Industry No: |
| DETAILS OF INJURY  |
| Mechanism of injury: |
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| Clinical description of original injury/injuries or disease: |
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| Is the present disablement solely attributable to the accident? Yes  |  |  No  |  |  |
| If yes, are there any additional contributory causes?  |
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| Has the clinical condition stabilised and not likely to improve? Yes  |  |  No  |  |  |
| ICD10 codes |  |  |  |  |  |  |  |  |
| Impairment findings: |
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| Date on which the employee is due to return to 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: |
|  |
|  | Code: |
| Signature: | Date: / / |
| **IMPORTANT:** Please submit all medical reports, radiographs, specialist tests or diagnostic procedures. These are essential if an employee is referred to an assessment clinic. |

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| FINAL MEDICAL EVALUATION REPORT |
| Describe in detail the impairment that has resulted from the injury. This will enable RMA’s assessor or the Compensation Commissioner to make a fair assessment of the disablement. Please use the hand, foot, eye or other support forms as required. Where necessary, please submit photographs. |
| Detailed clinical description: |
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| Name of doctor:  |
| Email: |
| Tel: | Cell No: |
| Signature: | Date of evaluation: / / |