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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Labour Coporate ID Text Con | | Claim Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_  **REQUEST FOR REOPENING OF A CLAIM - GENERAL**  **COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT 1993 (Act No. 130 of 1993)**  **PLEASE WRITE LEGIBLY** | | | | | | | | | | | | |
| Name of Employee | |  | | | | | | | | | | | | |
| Identity Number | |  | | Address | | |  | | | | | | | |
|  | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | Postal Code | |  |
| Name of Employer | |  | | | | | | | | | | | | |
| Address | |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | Postal Code | |  |
| 1. | Date of Accident/ Onset of Disease | |  | | | | | 2. | | | Date of Consultation | |  | |
| 3. | Has Permanent Disablement been awarded by COIDA? | | | | YES | NO | | | PERCENTAGE if known | | | |  | |
| 4. | State the specific diagnosis and the present condition of the employee. | | | | | | | | | | | | | |
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| 5. | List the special investigations performed to confirm (4) **(Attach report/s)** | | | | | | | | |  | | | | |
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|  | | | | | | | | | | | | | | |
| 6. | Describe the relationship of the present condition to the original injury/ disease sustained.  (If the only relationship is persistence of symptoms, provide dates of doctors’ consultations, diagnoses, treatment administered and attach sick leave records) | | | | | | | | | | | | | |
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| --- | --- | --- |
| 7. | Detailed treatment plan, with date of hospital admission and proposed procedure(s), name of hospital and estimated cost with codes to be used. (Please attach a separate page with this information, if the space provided is not enough) : | |
| ICD 10-Code: | | |
|  | | |
| Name of Radiology Department and Practice Number: | | |
|  | | |
| Date of when the investigation will be done: | | |
|  | | |
| COID Procedure Codes : for X-rays and MRI: | | |
|  | | |
| **NB!!! Kindly specify whether Left or Right.** | | |
|  | | |
|  | | |
| 8. | | How will the proposed treatment reduce the disablement the employee is suffering from? : |
|  | | |
|  | | |
| 9. | | Other health team members who will be involved during the procedure / treatment : : |
|  | | |
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**I certify that I have by examination, satisfied myself that the condition of the employee is the result of the accident as described above.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Signature of Medical Practitioner | | |  | Practice number |  |
| Name of Medical Practitioner | | |  | Date |  |
| Dr’s telephone number | | | Email address | Fax number | Cell |
| Address |  | | | | |
| Signature of the employee | |  | | Date(important) |  |
| Employee’s contact number | |  | | | |

**DOCTORS NAME STAMP** :