| 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: |
|  |
|  |
|  |
|  |
|  |
|  |
| Detailed clinical description of injuries/disease: |
|  |
|  |
|  |
|  |
|  |
| Are the injuries consistent with the mechanism of the injury? Yes |  |  No  |  |  |
| ICD10 Codes:  |  |  |  |  |  |  |  |  |
| Briefly describe any pre-existing condition or disease (if any): |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
| Treatment: Conservative |  |  X-rays |  | Surgery |  | Referral |  |   |
| Please give detail: |
|  |
|  |
|  |
|  |
|  |
|  |
| 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: |
|  |
|  | Code: |
| Signature: | Date: / / |