| final MEDICAL REPORT | | | | | | | | | | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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: | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| Clinical description of original injury/injuries or disease: | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| Is the present disablement solely attributable to the accident? Yes | | | | | | | |  | | | No | | | |  | |  | |
| If yes, are there any additional contributory causes? | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| Has the clinical condition stabilised and not likely to improve? Yes | | | | | | |  | | No | | | |  | | |  | | |
| ICD10 codes |  |  | |  |  |  | | | |  | | | | | |  | |  |
| Impairment findings: | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| 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. | | | | | | | | | | | | | | | | | | |

|  |  |
| --- | --- |
| 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: | |
|  | |
|  | |
|  | |
|  | |
|  | |
|  | |
|  | |
|  | |
|  | |
|  | |
|  | |
|  | |
|  | |
|  | |
|  | |
|  | |
|  | |
|  | |
|  | |
|  | |
|  | |
|  | |
| Name of doctor: | |
| Email: | |
| Tel: | Cell No: |
| Signature: | Date of evaluation: / / |