ANNEXURE 'A'

METAL AND ENGINEERING INDUSTRIES PERMANENT DISABILITY SCHEME

ENQUIRIES:
METAL INDUSTRIES HOUSE
27 FREDERICK STREET
JOHANNESBURG
2001

MEDICAL EXAMINATION AND REPORT ON WORKING CAPABILITIES

P.O. BOX 7507
JOHANNESBURG
2000
TEL: 870-2000
FAX: 870-2387

Please indicate: **Are you the member's doctor ?** ☐ **Are you the Scheme's appointed doctor?** ☐

Member's Full Names: ____________________

Identity number: ____________________ **Date of birth:** ____________________

A. 1. How long have you been the member's doctor? ____________________

2. Date on which member first consulted in connection with this disability: ____________________

3. Dates of subsequent consultations in connection with this disability: ____________________

4. Describe fully the nature and extent of the disability which causes member's inability to perform his/her normal duties: ____________________

____

a) What are the symptoms? ____________________

b) When did the symptoms first appear? ____________________

c) What was the cause? ____________________

d) Objective findings in detail: ____________________

____

5. Describe treatment prescribed and how successful this has been: ____________________

____

____

6. If no treatment, do you envisage any form of therapy being beneficial to the disability? ____________________

____

____

7. How long do you estimate the present incapacity will last? ____________________

i) What are the chances of partial or total recovery? ____________________

____

____

8. Was the member's disability aggravated by another cause?

a) Previous illness or injury: ____

b) Directly or indirectly by alcohol or drugs? ____

c) Self inflicted injury? ____

d) Inhalation of gas or fumes? ____

e) Does the claimant smoke? ____

9. Is the member's disability as a result of injury on duty or occupational disease? YES☐ NO☐

i) If **YES**, have you been responsible for the completion and submission of reports to the offices of the Compensation for Occupational Injuries and Diseases?

____

____

B. WORKING CAPABILITIES

Please circle the relevant answers.

1. Is the member's movement restricted in any way ?

1.1 Not at all
1.2 Very slightly
1.3 Moderately
1.4 Severely

2. What is the cause of the restriction in movement ?

2.1 Pain
2.2 Physical impairment
2.3 Combination of 2.1 and 2.2
2.4 Not applicable

3. Can the member move with ease over the following areas ?

3.1 Even terrain outside
3.2 Uneven terrain outside
3.3 Even terrain inside
3.4 Uneven terrain inside
3.5 All mentioned above

4. Does the member become short of breath or tired when :

4.1 Resting
4.2 Talking
4.3 Dressing
4.4 Walking
4.5 Running
4.6 None of the above

5. How many hours a day (exclude 8 hours for night rest) does the member need to REST ?

5.1 None
5.2 1 - 2 hours
5.3 3 - 4 hours
5.4 5 - 6 hours
5.5 > 6 hours

6. Strength Assessment :

Please rate strength in each part out of ten (**0 = Minimum ; 10 = Maximum**)

6.1 Right hand / 10
6.2 Left hand / 10
6.3 Right arm / 10
6.4 Left arm / 10
6.5 Right leg / 10
6.6 Left leg / 10

7. Reflexes :

7.1 Right biceps N ☐ ☐
7.2 Left biceps N ☐ ☐
7.3 Right knee N ☐ ☐
7.4 Left knee N ☐ ☐
7.5 Right ankle N ☐ ☐
7.6 Left ankle N ☐ ☐

8. Are there any OBJECTIVE signs of any of the following:
(Please send all ECG's and laboratory reports as confirmation)

8.1 Uncontrolled angina
8.2 Low ejection fraction
8.3 Impaired lung function
8.4 Kidney failure
8.5 Liver failure
8.6 Any other chronic condition. Please specify : ______________________________

9. How far can the member walk without becoming out of breath or tired ?

9.1 < 50m
9.2 50 - 100m
9.3 100 - 200m
9.4 200 - 500m
9.5 > 500m

10. What length of time would the member be able stand on his/her legs without resting ?

10.1 < 30 min
10.2 30 - 90 min
10.3 90 - 120 min
10.4 120 - 180 min
10.5 > 180 min

11. How many flights of stairs (15 per flight) can the member climb before becoming short of breath or tired?

11.1 Three flights
11.2 Two flights
11.3 One flight
11.4 Half a flight
11.5 Cannot climb any stairs at all

12. Does the member need any of the following in order to be able to move around?

12.1 One crutch
12.2 Two crutches
12.3 Walking frame
12.4 Wheelchair

13. Is the member confined to:

15.1 The house
15.2 The bed

I HEREBY DECLARE THAT THIS REPORT IS A TRUE REFLECTION OF THE CURRENT SITUATION CONCERNING THE ABOVE-MENTIONED MEMBER AND TO THE BEST OF MY KNOWLEDGE EVERYTHING STATED HEREIN IS THE TRUTH.

SIGNED AT ______________________________ ON ________________________________ 20 ________

DOCTOR'S SIGNATURE : __________________________________

DOCTOR'S NAME : __________________________________

DOCTOR'S ADDRESS : __________________________________

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____

____

DOCTOR'S TELEPHONE NO : __________________________________

DOCTOR'S FAX NO : __________________________________