SICKNESS CLAIM FOR CONDITIONS OF PSYCHOLOGICAL NATURE
DECLARATION BY TREATING PSYCHIATRIST

The Professional Provident Society Holdings Trust No IT 312/2011 (PPS) is a Registered South African Trust
The Professional Provident Society Insurance Company Limited Reg. No 2001/017730/06 (PPS Insurance)
PPS is a Licensed Insurer and Financial Services Provider

Dear Doctor,

We appreciate your time and cooperation to assist us in considering a Sickness benefit claim for your patient.

The following is important:

- PPS has signed consent from your patient to obtain confidential medical information from you.
- Please attach copies of all special investigations and specialist reports hereto.
- Any costs to provide this information will be for your patient's account.
- **Please send the completed form and supporting documents to:**
  - **Fax: 011 644 4520, or**
  - **E-mail: claims @pps.co.za**
- Your prompt response will be appreciated.

PART A: MEMBER DETAILS

Member Number: | | | | | | | | | | National ID Number: | | | | | | | | | | | | | |

Surname: | | | | | | | | | | | | | | | | | | | | | | | | | Initials: | | |

PART B: CLAIM DATES

1. **TOTAL BENEFITS:** The claimant was unable to perform ANY professional duties from:

D D / M M / Y Y Y Y to D D / M M / Y Y Y Y

NOTE: In order for you to book your patient off for Total benefits he/she must not be able to perform any of the occupational duties normally associated with his/her occupation, whether physical or mental tasks, including minor physical tasks such as consulting, or administrative tasks.

2. **PARTIAL BENEFITS:** The claimant was able to perform some professional duties from:

D D / M M / Y Y Y Y to D D / M M / Y Y Y Y

NOTE: to qualify for Partial benefits your patient should be able to carry out some of his/her normal occupational duties, or work reduced working hours compared to normal working hours, but not all. PPS Claims will also assess this in line with the occupation and profession.

When did your patient resume his / her usual professional duties on a full-time basis?

D D / M M / Y Y Y Y

If your patient has not returned work, please indicate expected return to work date

Full time: D D / M M / Y Y Y Y Part time: D D / M M / Y Y Y Y

PART C: DETAILS OF MEDICAL CONDITION

1. Diagnosis and date diagnosed

DSM V Diagnosis	ICD 10 code	Date diagnosed
Please include the WHODAS score if available		

2. DSMIV diagnosis inclusive of the GAF score

3. History of condition

a. Since when has the patient been treated for this or a related condition? Provide a brief history (including dates), of the onset of symptoms and nature of events leading up to the initial and subsequent diagnosis:

b. Provide details of any current or previous substance abuse, inclusive of admission details for associated treatment, if applicable:

c. Please provide details of any family history of mental illness:

d. History of suicide attempts known to you? Yes ☐ No ☐

If yes, kindly provide comprehensive details below:

Nature of attempt	Date	Admission to hospital (Y/N)	Name of institution/ duration of admission	Name and contact details of treating doctor
		Y N		
		Y N		
		Y N		

PART D: CURRENT CLINICAL PRESENTATION

1. Provide a full description of your patient's self-reported complaints:

2. Provide your objective clinical examination/mental state examination findings, in particular detailing (but not limited to): general appearance, mood, anxiety, psychotic features, mental state, cognitive and social functioning.

3. Describe any psychosocial, work or environmental factors influencing the patient's condition and/or response to treatment:

4. Describe in detail the extent of the patient's impairment:

5. Provide details indicating the severity and permanence of the condition (short and long term prognosis):

6. Do you suspect any neurological deficit, please elaborate:

7. Provide details of any known general medical condition/s which may contribute to the condition:

PART E : DETAILS OF TREATMENT TO DATE

1. Describe the previous and current **pharmacological** treatment that the claimant has/is receiving for his/her condition. Please include names, dosages and dates/duration of all medication.

a. **Previous medication :**

Name	Dosages	Length of treatment

b. **Current medication:**

Name	Dosages	Length of treatment

c. **Psychotherapy details**

i. Has your patient received any psychotherapy? Yes ☐ No ☐

ii. If yes, is he/she compliant with these therapy sessions? Yes ☐ No ☐

iii. If the answer is no to both questions, please explain.

d. **Hospitalisation**

Institution/Hospital	Dates of admission and discharge	Reason for hospitalisation

e. In your opinion has the patient reached maximal medical therapy? Yes ☐ No ☐

If not, please explain:

f. Comment on the claimant's adherence to treatment. If not compliant, please provide detailed explanation:

g. Comment on potential of further treatment options (Please specify treatment method, dosages, frequency of consultations, etc.)

h. In your experience, can you give an indication of the expected recovery period necessary for this member and his/her condition?

PART F : CONSULTATION HISTORY

1. Date of your first ever consultation with the claimant. D D / M M / Y Y Y Y
2. Date of your first consultation with regard to the current symptomology. D D / M M / Y Y Y Y
3. Date of your most recent consultation with the claimant. D D / M M / Y Y Y Y
4. How frequently do you see the claimant (e.g. weekly, bi-weekly, monthly).
5. Consultations with other medical practitioners including specialists which you are aware of? Yes ☐ No ☐

5.1 If you answered yes to question 5, please provide details below:

Name	Nature of Illness	Date of consultation	Contact details if known

PART G : VOCATIONAL INFORMATION

1. Provide brief details of the claimant's current occupation:

2. What tasks/duties is the claimant unable to perform and why can't they perform the duties/tasks?

3. What tasks/duties is the claimant able to perform?

4. When is the claimant expected to be able to return to work?

5. Has the claimant made any requests for or been offered reasonable accommodation(s) at work? Please provide details.

PART H : TREATING PSYCHIATRIST DETAILS

HPCSA Reg No: Practice No:

Surname: Initials:

Telephone No: Fax No:

Email Address:

Address:

Signed at: this day of 20

Signature of medical Psychiatrist: