SICKNESS CLAIM FOR CONDITIONS OF PSYCHOLOGICAL NATURE

(DECLARATION BY TREATING PSYCHIATRIST)

Dear Doctor,
We appreciate your time and cooperation in assisting PPS to assess your patient's claim accurately.

Kindly provide comprehensive answers to the questions listed below and attach copies of all relevant investigations available to you.

PPS obtained prior written consent from the life insured in terms of which medical information pertaining to the claim may be provided. In terms of the Promotion of Access to Information Act 2 of 2000 (POPIA), and other applicable legislation, PPS may also be obliged to release such medical information obtained as part of the claims assessment process to the policyholder at their request. Furthermore, PPS may be legally obliged to share the medical information with a third party in accordance with the laws of the Republic of South Africa, including but not limited to POPIA.

By providing the medical information, you hereby consent to the sharing and further processing thereof. PPS undertakes that it will share and process such medical information in accordance with the purpose for which it was collected, which may include instances of complaints or dispute resolution. However, the utmost care will be taken to prevent any unreasonable or unlawful disclosure.

Please send the fully completed form and supporting documentation to PPS Claims at claims@pps.co.za

PART A: MEMBER DETAILS

Member number: ______ ID number: ______

Surname: ______ Initials: ______

PART B: CLAIM DATES

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

__ / __ / ____ to __ / __ / ____

NOTE: To qualify for Total benefits, your patient must not be able to perform any of the occupational duties normally associated with their occupation, whether physical or mental tasks, including minor physical tasks such as consulting, or administrative tasks.

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

__ / __ / ____ to __ / __ / ____

NOTE: To qualify for Partial benefits, your patient should be able to carry out some of their 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 their usual professional duties on a full-time basis?

__ / __ / ____

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

Full time: __ / __ / ____ Part time: __ / __ / ____

PART C: DETAILS OF MEDICAL CONDITION

1. Diagnosis and date diagnosed

DSM V diagnosis description	ICD 10 code	Date diagnosed

Please include the WHODAS score if available

2. DSMIV diagnosis inclusive of the GAF score, if DSM V diagnosis is not available.

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 patient has/is receiving for their condition. Please include names, dosages and dates/duration of all medication.

a. Previous medication :

Name	Dosages	Length of treatment (please specify the start date)

b. Current medication:

Name	Dosages	Length of treatment (please specify the start date)

c. Psychotherapy details

i. Has your patient received any psychotherapy? YES ☐ NO ☐

ii. If yes, are they 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 NO, please explain:

f. Comment on the patient'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 their condition?

PART F : CONSULTATION HISTORY

1. Date of your first ever consultation with the patient: ☐☐ / ☐☐ / ☐☐☐☐
2. Date of your first consultation with regard to the current symptomology: ☐☐ / ☐☐ / ☐☐☐☐
3. Date of your most recent consultation with the patient: ☐☐ / ☐☐ / ☐☐☐☐
4. How frequently do you see the patient (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 patient's current occupation:

2. What tasks/duties is the patient unable to perform and why can they not perform the duties/tasks?

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

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

5. Has the patient 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:

E-mail:

Address:

Signed at: this day of 20

Signature of psychiatrist: