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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):								

Please email to: rmascannings@randmutual.co.za
For queries contact us on: 0860 222 132

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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: / /

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