Assessment report by
medical practitioner (Disability)

gems
Government Employees Medical Scheme

To be completed in full by a medical practitioner and submitted to GEMS in any of the following manners:

- Post to **GEMS, Private Bag x782, Cape Town, 8000 or**
- Fax to **0861 00 4367**

Section A: Member personal details

Membership no

Surname

Full first name/s

Main member ☐ Yes ☐ No ID no

Tel no (H) ( ) (W) ( )

Cell phone no Fax no ( )

Postal address

Code

Section B: Dependant (patient) personal details

Surname

Full first name/s

ID no Date of birth D D M M Y Y Y Y

Section C: Medical history

For how long have you been the doctor? (If not his/her treating doctor, please indicate.)

Was the patient referred to any other medical practitioner? ☐ Yes ☐ No

If YES, please provide details and attach the relevant reports

When did you last attend to the patient?

How long have you been the patients, doctor?

Please give full details of the condition for which you are treating the patient

Section C: Medical history (continued)

Date of commencement of condition D D M M Y Y Y Y

Subsequent consultations regarding this condition

Date		Reason for consultation	Diagnosis	Treatment	Result
From	To				

Section D: Patient's condition

Describe fully the patient's present condition with specific detail to the loss of limbs, eye sight, mental ability, mobility etc.

Is the condition totally and permanently incapacitating? ☐ Yes ☐ No

If YES, please describe in detail to what extent the patient is incapacitated

If NO, what is the likelihood of either partial or complete recovery? ☐ High ☐ Medium ☐ Low

What is the probation duration of the disability?

Is there potential for rehabilitation? Give details

Section E: Doctor's declaration

I certify that I have personally attended to the patient and the above statements are correct to the best of my knowledge.

Sign at ______________________ this __________ day of ______________________ 20 ________

Signature of medical attendant ____

Initials [ ] Surname [ ]

Tel no (W) ( ) [ ] Fax no ( ) [ ]

Cell phone no [ ]

Postal address [ ]

[ ] Code [ ]

Qualifications ______________________________ Practice no [ ]

Comments ____