Form F: Medical Assessment for Disability

Part I. PERSONAL INFORMATION

Name: ..... Age/Sex: .....
Nationality: .....
CID/Passport/Voter ID/Employer ID No: .....
Occupation: ..... Contact No: .....
Address: .....

Part II. EMPLOYER DETAILS:

Name of Employer: .....
Employer's address: .....

Part III. HISTORY OF INJURY/ILLNESS (from the worker):

Date of injury/ diseases first noticed: .....
Workplace location where injury/ disease occurred: .....
Description of how the injury/ disease occurred: .....
Description of the injury or diseases: .....
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Part IV. MEDICAL ASSESSMENT:

Date & Time of Examination: ..... Place of Examination: .....

Past Medical History (*relevant to the current condition as well as refer to the pre –employment medical condition*):

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Examination Findings:

a) General physical examination:

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b) Systemic examination:

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c) Local Examination:

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Laboratory /Diagnostic Investigations: .....

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Diagnosis: .....

V. MEDICAL MANAGEMENT PLAN:

Treatment:

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Medication: ……

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Referral to Hospital:

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Referral to Specialist (specialty /name):

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Referral to Allied Health Professionals;

☐ a) Physiotherapist

☐ b) Vocational rehabilitation

☐ c) Others;

Review Date: Worker to be reviewed on : ……