THE FEDERATED EMPLOYERS MUTUAL ASSURANCE COMPANY (RF) (PTY) LTD

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OCCUPATIONAL INJURIES AND DISEASE
COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993 AS AMENDED
BACK INJURY

EMPLOYEE DETAILS

Claim Number:	**Date of Accident:**	**Staff Number:**
Name of Employer:		
Name of Employee:		

1.	Injured side:	Cervical		Thoracic			
	Lumbar	Sacral		Coccyx			
	History						
	Please provide details of the pre-existing condition						
2.	Do you have knowledge of any previous back problems?			Yes		No	
	If the answer is no, please explain:						
3.	Has the employee previously attended by yourself or any other medical practitioner for back problems or related symptoms? If yes give details and the name of the Doctor						
4.	Mechanism of injury						
5.	Please describe in full the surgery performed						
6.	Effect on activities of daily living (ADL)						
7.	Residual symptoms:						
	Headache/pain		Yes		No		
	Please specify/describe						
	Radicular signs:						

PHYSICAL EXIMINATION

8.	Inspection	
	Muscle wasting and weakness:	
	Posture (scoliosis, kyphosis, muscles spasm):	
	Gait and balance	
	Palpitation	
	Active Movements (of different regions)	
	Flexion:	
	Extension:	
	Lateral flexion:	

	Rotation:	
	Ability to stand:	
	Toe and heel walk:	
	Ability to squat:	
8.	Muscle function:	
	Shoulder (C1-5)	
	Elbow (C5-7)	
	Wrist (C6)	
	Fingers and thumb (C8-T1):	
	Give comments on physiological stability:	
11.	Straight leg raising:	
	Lasegue:	
	Bowstring:	
	Radiculopathy:	
12.	Sensation dermatomes:	
13.	Bladder and Bowel dysfunction:	
14.	Electric diagnostic testing (EMG)	
15.	Radiology Report: please attach the latest report	
	Other comments:	

I certify that I have examined the employee and, satisfied myself that the injury (ies) of the employee is the result of the accident as described above. NB: This report must be sent to FEM or handed to the injured employee within 14 days from the date of first consultation.

DECLARATION	
I hereby declare that the information provided in this report is true and correct according to my knowledge.	
Initial Surname:	Practice No
E-mail:	Tel:
Signature:	Date: