# DEPARTEMENT OF LABOUR
# COMPENSATION FUND

Claim number. .....

## FIRST MEDICAL REPORT IN RESPECT OF A WORK RELATED UPPER LIMB DISORDER (WRULD)

### COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993
### (Act No. 130 of 1993)
### [Section 6A(b) – Commissioner's rules, forms and particulars – Annexure 25]

This form must be completed by a medical practitioner and sent to the Compensation Commissioner, P O Box 955, Pretoria 0001

Employee: Surname: Identity number:

First names:

Address: Code:

Employer:

Address: Code:

1. Date symptoms first started: 2. Date of first consultation. 3. Date of specific diagnosis:

4. Specific diagnosis of this upper limb disorder:

5. The symptoms the employee experience (tick the appropriate box/es):

☐ Burning sensation ☐ Fatigability ☐ Loss of grip strength

☐ Loss of normal sensation ☐ Muscle weakness ☐ Pain

☐ Paraesthesia (tingling) ☐ Sensation of cold ☐ Swelling

☐ Stiffness and cramps

Describe:

6. The clinical signs found on examination (tick the appropriate box/es)

☐ Burning sensation ☐ Fatigability ☐ Loss of grip strength

☐ Loss of normal sensation ☐ Muscle weakness ☐ Pain

☐ Paraesthesia (tinging) ☐ Sensation of cold ☐ Swelling

☐ Stiffness and cramps

Describe:

7 Is the employee left or right handed? Right Left Sex: Male Female Age: years

8. Height of employee cm Weight of employee kg Body mass index:

9 Which special medical investigation/s and/or job analysis/ergonomic assessments were done to prove the diagnosis and/or what other potential causes of the above-mentioned upper limb disorder have been investigated/eliminated? (Where applicable, please attach these reports.

10 Does the employee suffer from any other diseases? (If so, please specify)

11 Describe the nature of any previous injuries sustained and/or abnormalities to the employee's upper limb/s?

*Encircle correct answer

Please turn over and complete reverse side

risk factors (Where applicable, attach photos, diagrams and/or job analysis/ergonomic assessment):

| Risk factor | Percentage of working day | Briefly describe the job task where this risk factor occurs and quantify in terms of repetitions/duration/strength required/range of movement, etc. |
|---|---|---|
| Repetitive movements | | |
| Movements Requiring force | | |
| Movements at the Extremes of reach | | |
| Static muscle loading | | |
| Awkward sustained postures | | |
| Contact stress | | |
| Vibration | | |
| Low temperatures | | |

13. How long has the employee been doing this job? _____ years _____ month

14. Explain how this alleged occupational disease progressed over a period of time in terms of function (i.e. signs and symptoms with relation to job tasks) (e.g. wrist pain started after 8 hours of sewing 6 months ago (no clinical signs). Currently increased pain after 30 minutes of sewing with pain keeping her out of sleep. Positive Phalen and Tinal tests and reduction in grip strength.)

15. Have any of the employee's colleagues, performing a similar job, complained of similar symptoms? If yes, explain. Yes / No

16. Explain how this condition was managed before this specific diagnosis was made in terms of:

a) The Person Medically (e.g. medication, surgery, etc.):

Functionally (e.g. rehabilitation, etc.):

b) The job Task adaptation (e.g. job rotation, shorter hours, etc.):

Equipment adaptation (e.g. extended handle on tool used, etc.):

17. Is the employee currently fit to work? Yes / No If yes, is he/she performing his/her* Usual work or Alternate/Adapted work

If the employee is performing alternate/adapted work, is this position* Temporary or Permanent?

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**I certify that I have by examination of the employee, satisfied myself of the above-mentioned facts.**

Signature (Medical Practitioner):

Registered address with HPCSA:

Name (printed):

Qualifications:

Code:

Practice number:

**Date (Important):**

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IMPORTANT:

* All questions must be answered in full (use extra paper if necessary).
* Full motivation of diagnosis will prevent unnecessary correspondence and delays in adjudication of claim.
* The form must be forwarded to the employer within 14 days after the specific diagnosis was made. The employer must forward this report to the Compensation Commissioner.
* Please submit medical accounts separately. Attach a copy of this report is your account.
* It is advisable to consult the Compensation Commissioner's "Guidelines for Managing Work-Related Upper Limb Disorders" before reporting this condition.
* The employer must submit a copy of this report to the Provincial Executive Manager of the Department of Labour (Occupational Health and Safety Act) or the Regional Principal Inspector of Mines (Mine Health and Safety Act)
* The employer must submit a Progress Medical Report (W.CI. 302) and a Resumption Report (W.CI. 6) on a monthly basis to the Compensation Commissioner or Mutual Association or employer individually liable, as the case may be, until the employee's condition has become stabilised, when a Final Medical Report (W.CI. 302) should be submitted.

*Encircle correct answer