



FUNCTIONAL / MEDICAL ASSESSMENT: REFERRAL FORM

NB: Please write legibly and complete in capital letters

PART A: CLIENT'S PRIMARY INFORMATION

Identity Number		<input type="checkbox"/> Male	<input type="checkbox"/> Female
Form of Identification	ID	Other methods of identification Specify	
Surname			
Full Name(s)			

PART B: CLIENT'S MEDICAL HISTORY (TO BE COMPLETED BY TREATING CLINICIAN / INSTITUTION)

I have confirmed the client's name & ID number		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you the client's *regular treating clinician or institution?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<small>*Regular means clinical care or management for a period of 3 months or more by a health practitioner, clinic or hospital</small>			
If your answer no above, what supports your completing of this form? E.g. obvious disability		Elaborate:	
Presenting problem / symptoms			
Diagnosis			
Complications, if any			
The client is compliant with treatment		<input type="checkbox"/> Yes	<input type="checkbox"/> No
The client abuses illegal substances		<input type="checkbox"/> Yes	<input type="checkbox"/> No
How has the medical condition changed over the past 6 months?		<input type="checkbox"/> Improved	<input type="checkbox"/> Stabilized
		<input type="checkbox"/> Worsened	
Elaborate			
Remarks on functionality			
Recommended Health Practitioner to conduct an Assessment:		<input type="checkbox"/> MP	<input type="checkbox"/> PT
		<input type="checkbox"/> OT	<input type="checkbox"/> AUD
		<input type="checkbox"/> Other:	

PART C: DECLARATION

All information furnished by me in this referral form is true and correct to the best of my knowledge.

Warning! According to:

- Social Assistance Act 13 of 2004 Section 30 states that: (a) "A person is guilty of an offence if he or she intentionally furnishes the Agency with false or misleading information"
- Social Assistance Act 13 of 2004 Section 31 states that: "A person convicted of an offence in terms of this Act is liable to a fine or imprisonment for a period not exceeding 15 years of both a fine and such imprisonment".

Practitioner full names																				
Practitioner Signature	Treating Facility or Practitioner Stamp HPCSA Reg. <input type="checkbox"/> SANC <input type="checkbox"/>																			
Date											d	d	/	m	m	/	L	C	y	y
Tel:																				
Cell:																				

Mark with ✓ the correct box and supply relevant practitioner no.

SASSA will verify the credentials of the referring clinician and we reserve the right to conduct quality assurance on all completed medical referral forms.