FUNCTIONAL / MEDICAL ASSESSMENT: REFERRAL FORM

NB: Please write legibly and complete in capital letters

PART A: CLIENT'S PRIMARY INFORMATION

Identity Number			Male		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		Yes	No	
Are you the client's *regular treating clinician or institution?		Yes	No	

** Regular means clinical care or management for a period of 3 months or more by a health practitioner, clinic or hospital*

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		Yes	No		The client abuses illegal substances		Yes	No	

How has the medical condition changed over the past 3 months?		Improved		Stabilized		Worsened

Elaborate	
Remarks on functionality	

Recommended Health Practitioner to conduct an Assessment:	MP	PT	OT	AUD	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*
Date	d d / m m / c c y y	
Tel:		
Cell:		HPCSA Reg. / SANC

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.