DISABILITY GRANT ASSESSMENTS AT NQUTU KWAZULU - NATAL.

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To my wife, Ntombenhle, who provided an excellent secretarial service in the preparation of this report.

To my two children, Vuyelwa and Teboho, the constraints on your quality time are over..... for the time being!

CONTENTS

SUMMARY

This study was for sentimental reasons planned to cover the immediate pre and post election periods.

It is a retrospective study spanning the period 11 April 1994 to 17 June 1994. The study sought to determine the social, medical and administrative factors which may have an influence on the outcome of disability grant assessments and outcome.

145 applicants were assessed during the study period and 11 were subsequently rejected because of incomplete data. As a result, only 134 subjects were included in the study.

The epidemiological parameters probed were gender, age, marital status, residence, education, employment status, reason for applying, past medical records, clinical assessment, disability and result of assessment.

The influence of these various parameters on the outcome of the disability grant assessments are considered as well as the problems encountered during the study.

The study also highlights the problems of illiteracy, a high unemployment rate, abject poverty, inadequate health services and an inadequate social relief scheme and the association of these problems with the frequency of applications and consequently, a more lenient assessment of disability.

Finally, the author argues for a revision of the Social Pensions Scheme policy of the government.

INTRODUCTION

In the post election KwaZulu - Natal province, the various apartheid departments are still functioning as independent units for all practical purposes. Disability grant assessments are still processed according to the former KwaZulu homeland guidelines and regulations in this area.

The Social Pensions Act No 37 of 1973 and its amendments coupled with the Bantu Homelands Constitution Act No 21 of 1971 ensured the introduction of social pensions to Blacks living in the homelands[1]. The various Departments of Welfare of the Homeland Governments delegated these functions to the District Pensions officers who are the Magistrates of the areas and who in turn delegated these functions to their duly authorised officers.

The duty of the Pensions Officer is to assess whether a prospective applicant qualifies to be considered for a disability grant by the District Surgeon or Government Medical Officer. A person must satisfy the following criteria in order to qualify for a disability grant:-

(1) 16 yrs or above in age

(2) must be indigent

(3) unable to engage in meaningful employment owing to physical or mental disability.

(4) a citizen of KwaZulu

In our area, the Pensions Officer admitted that the Means Test to determine whether a person is indigent or not was seldom applied in practice[1]. In fact, the Pensions Officers were not even aware of any departmental guidelines pertaining to disability grant assessments[2]. It is therefore not suprising that medically boarded persons with adequate pensions who would otherwise not pass a Means Test are frequently presented to the District Surgeon with application forms for a disability grant. As the District Surgeon's duty is to assess medical disability, in most instances these people were awarded disability grants which they were not entitled to receive.

Most departmental guidelines promote a strictly physical assessment of disability and discourages the personal and contextual factors at play to be considered. The KwaZulu guidelines stresses the fact that 'the main criterion in considering disablement should be strictly inability for remunerative work'[2]. Leger and Arkles[3] raise the fact that in reality other factors like education, age and personality have a bearing on the actual disability of an injured workman. Dick, Spencer et al[4] in their article on chronic illness, make a strong case for a holistic approach to disability assessment that includes the individual's perceptions as well as the interactions with family, community and socio-economic factors. Geoff Baron[5] also makes a strong case for this 3 stage diagnosis.

The often nonavailability of experienced medical staff in the rural areas results in suboptimum control of manageable diseases like asthma and epilepsy to name only a few[7]. Awarding temporary grants to these patients promotes the "dependency syndrome" and thus a vicious cycle is maintained.

The belief by the community, which is further heightened by traditional leaders, Village Health Workers (oNompilo) as well as Paralegal groups - that anyone who has had an operation or suffers from asthma, hypertension, epilepsy or any other chronic disease, qualifies for a disability grant[6] is an unfortunate price that the tax payer has to pay for years of neglect of large sectors of our population by previous apartheid policies.

In this depressed economic climate, the District Surgeon is under tremendous pressure to award disability grants. His work is not made any easier by the abject poverty of the applicants and virtually no possibility of social relief grants. Personal communication with Social Welfare Officers in this area[10] revealed that they are still dependent on the Magistrate for funds. They only make recommendations for social relief which are then paid out at the discretion of the Magistrate. Social relief grants appear to be a "one off" grant of not more than R150.00. They were also frustrated by the fact that the Magistrate could also release social relief grants independently of the Social Workers. Social Relief funds were in some instances used for purposes other than social relief eg for pauper burials, without the consent of the Social Welfare Officers

It is hoped that this study will stimulate interest in this field by raising some pertinent points.

OBJECTIVES

(1) To determine the demography, referral details, medical and social status of disability grant applicants within the jurisdiction of Nqutu, KwaZulu - Natal.

(2) To document any guidelines available for disability grant certification, and thereafter to formulate appropriate guidelines if necessary.

(3) To make recommendations concerning improvements thought to be necessary with regard to disability grant certification in this country.

DEFINITIONS

(1) **APPLICANT:** any person who presents himself to the pensions officer or district surgeon applying for a disability grant.

(2) **ASSESSMENT:** to establish the degree of disability or chronic illness of a person according to certain criteria.

(3) **MEDICAL OFFICER:** any medical practitioner in the service of the State including the Homeland administrations.

(4) **MEDICAL PRACTITIONER:** any person registered as a medical practitioner or intern under the Medical and Supplementary Health Professions Act, 1974 (Act No 56 of 1974).

(5) **PENSIONS OFFICER:** any officer delegated in terms of the Social Pensions Act No 37 of 1973 who deals with social pensions in the Magistrates office.

(6) **DISABILITY:** any restriction or inability to perform an activity which would be regarded as within the range of a normal person

(7) **SOCIAL RELIEF:** temporary material assistance to an applicant.

(8) **DISTRICT SURGEON:** a medical practitioner in the employ of the State whose duties include disability grant assessment certification and other medico-legal duties.

(9) **FAMILY PHYCISIAN:** a medical practitioner who has had postgraduate training in the biopsychosocial model of family medicine and who is registered with the South African Medical and Dental Council (S.A.M.D.C) as a Family Physician.

METHODOLOGY

SAMPLE

145 applicants were seen during the study period and 11 were rejected because of incomplete information from the sample group. The study therefore involved 134 subjects. A pilot study of 20 subjects was done and is included in the figure of 134. A control group was not necessary.

METHOD OF DATA COLLECTION

Permission to conduct the study was obtained from the Secretary for Health KwaZulu. The study period extended from 11 April 1994 to 17 June 1994. All applicants in this period were assessed by the author. The data was extracted from district surgeon records kept during this period and the information was then tranferred onto a questionnaire retrospectively.The questionaire consisted of the following points:-

(i) identity: age, gender, marital status, educational level, number of dependents.

(ii) occupation: scholar, housewife, retrenched, medically boarded, unemployed.

(iii) source of referral: health services, welfare, self, employer.

(iv) reason for referral: review, medical, poverty, ignorance.

(v) clinical status: psychiatric, medical, surgical, well.

(vi) result of assessment: granted/ declined/ deferred.

A maximum of 5 applicants were processed per day on an appointment system controlled by the Pensions Officers during the study period.

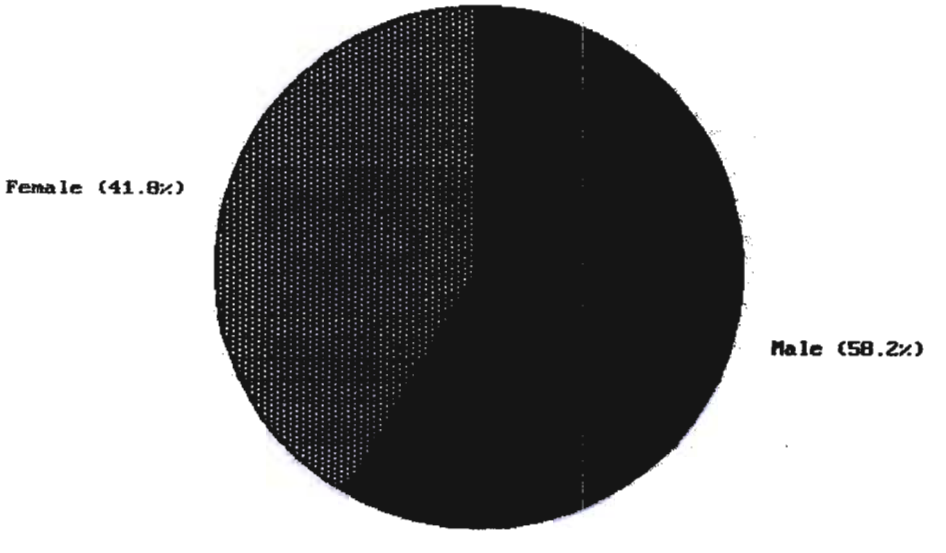
COLLATION AND ANALYSIS OF DATA

The data was extracted from district surgeon records kept during the study period and later entered onto the questionnaire. Statistical analysis was undertaken by the Medical Research Council in Durban.

RESULTS

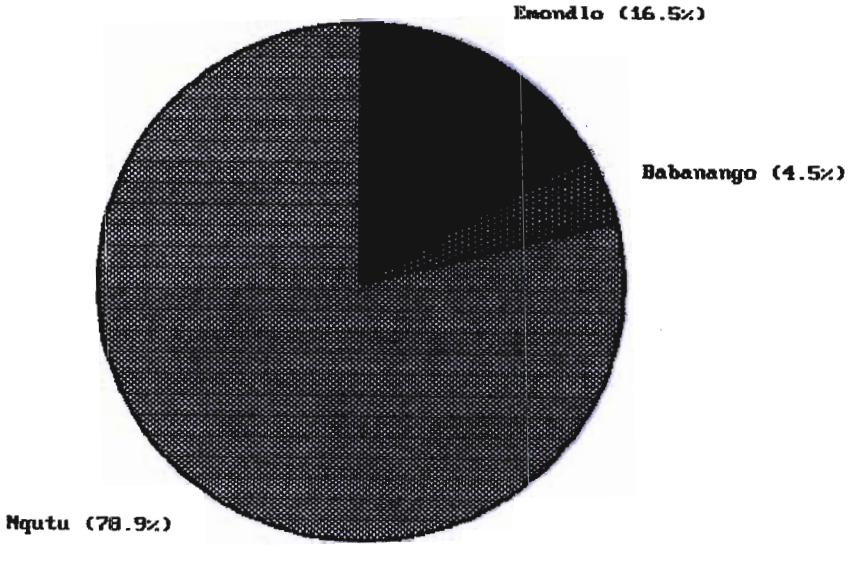
A total of 134 subjects were included in the sample group. All applicants were of African origin. There were 78 (58,2%) males and 56 (41,8%) females and the male/female ratio was 6:4.

GENDER
FIGURE 1



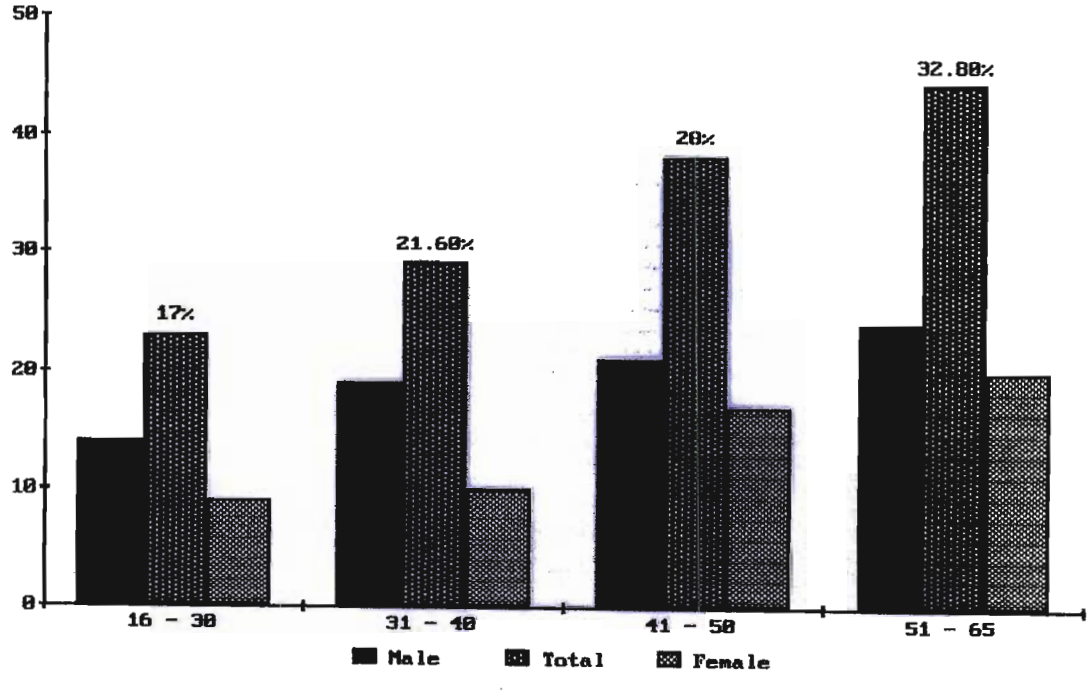
Most of the applicants resided in the greater Nqutu area 105 (78,9%), Emondlo 22 (16,5%), Babanango 6 (4,5%).

RESIDENCE
FIGURE 2



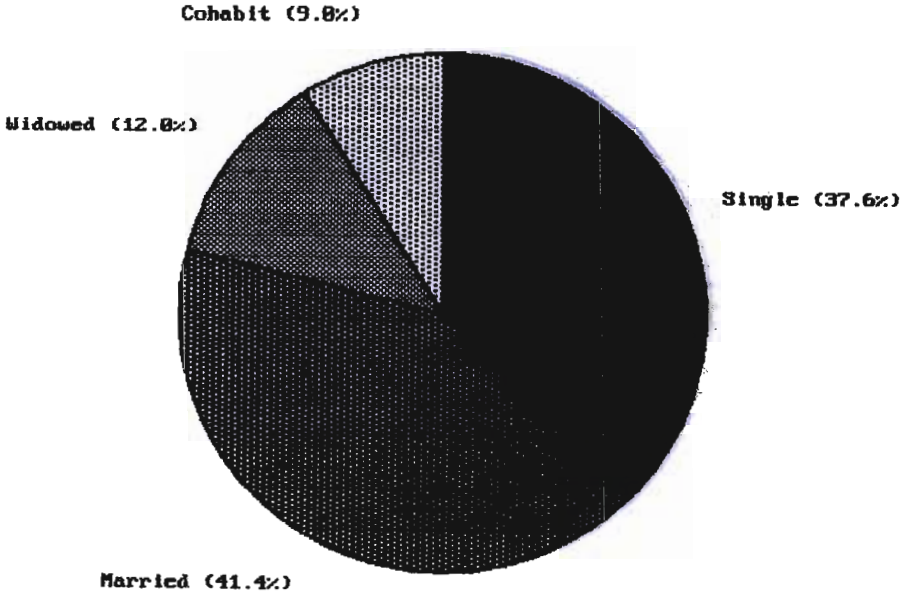
Age /Gender characteristics showed predictably a preponderance of males in all age groups. The majority of applicants came from the above 50yrs group, 44 (32,80%), followed by the 41- 50yrs group, 38 (28%).

AGE / GENDER
FIGURE 3



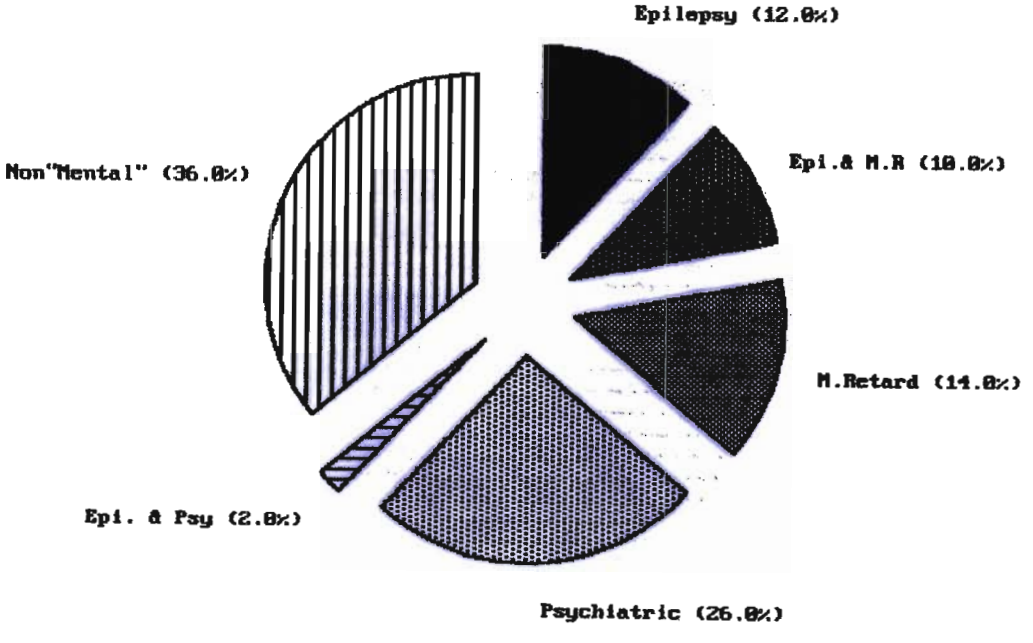
The majority of applicants were married 55 (41,4%) followed by a large group of single applicants 50 (37,6%).

MARITAL STATUS
FIGURE 4a



32 (64%) of the single applicants had a significant psychiatric problem which qualified them for a disability grant.

SINGLE / PSYCHIATRIC
FIGURE 4b



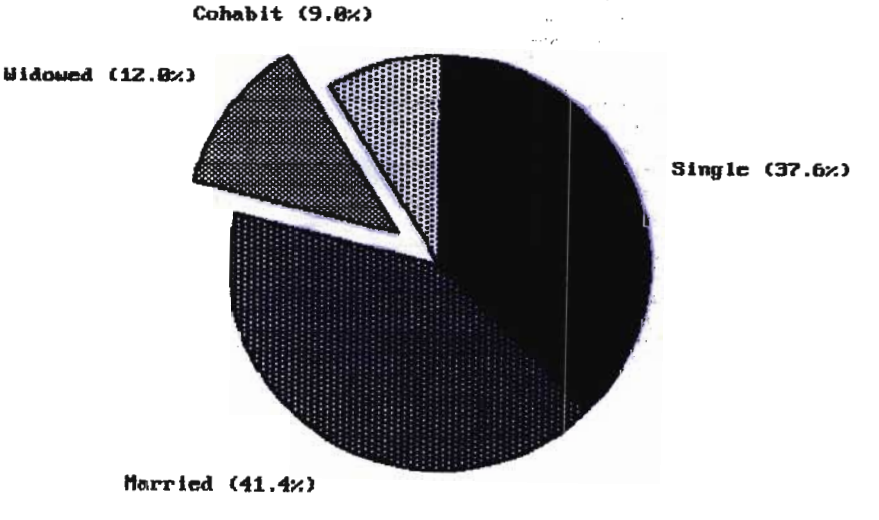
MALE 3

WIDOWED <

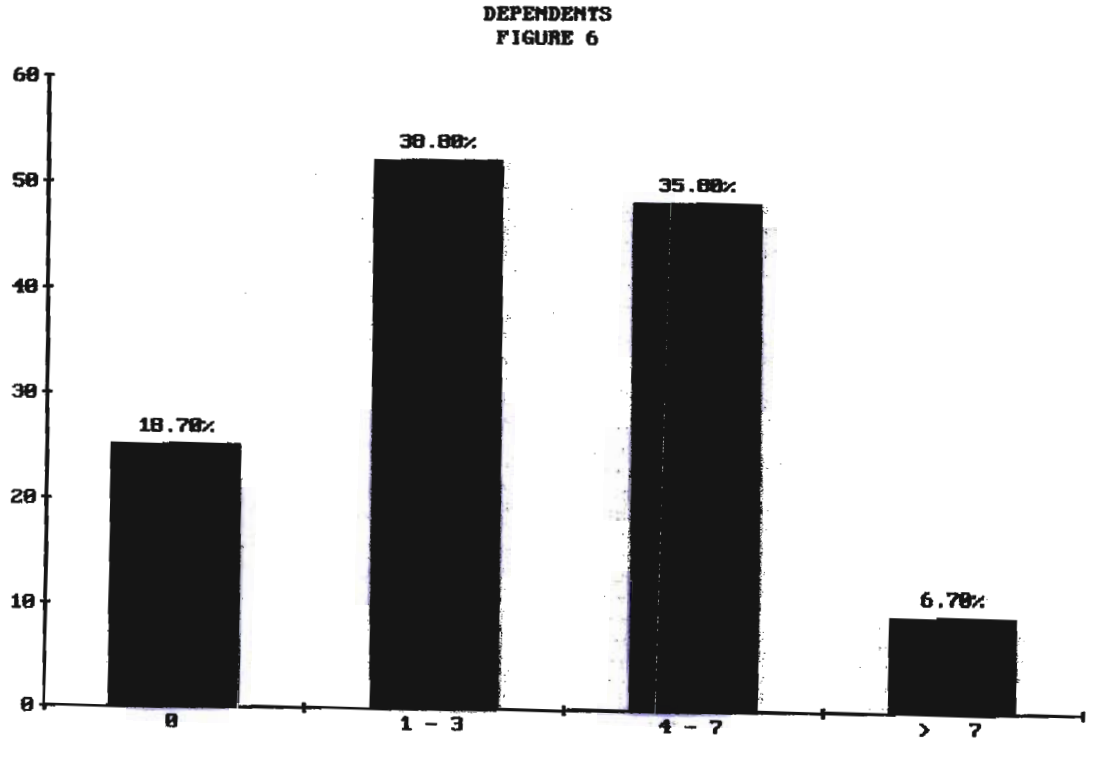
FEMALE 13

The widowed group is important since in traditional communities, females were at most allowed only an elemental education as they were not expected to join the labour markets in their adulthood. The problem arises when the spouse dies, usually in late middle age. They are usually reluctant to join the labour market at this late hour and expect some form of social pension or assistance from the state.

WIDOWED GROUP
FIGURE 5



The majority of applicants had 1-3 dependants , 52 (38,8%), followed by the 4-7 dependants group with 48 (35,8%) dependants.



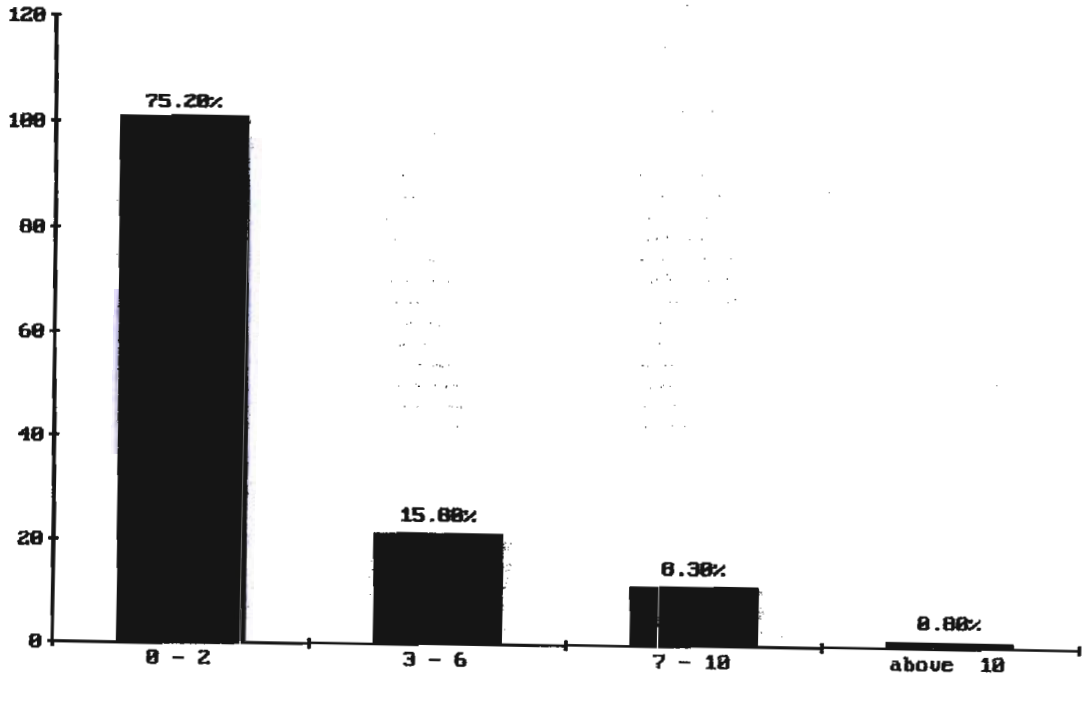
Applicants who were attending school at the time of assessment were 3 , 2 of whom were attending normal schools and 1 a special school. Two of them were males and one was a female.

All three of them, were in the Std 7 - 10 educational level. Two of them, both males, had old paralytic polio with fairly reasonable leg function. The female applicant had an arthrodesis of the knee following a traumatic injury.

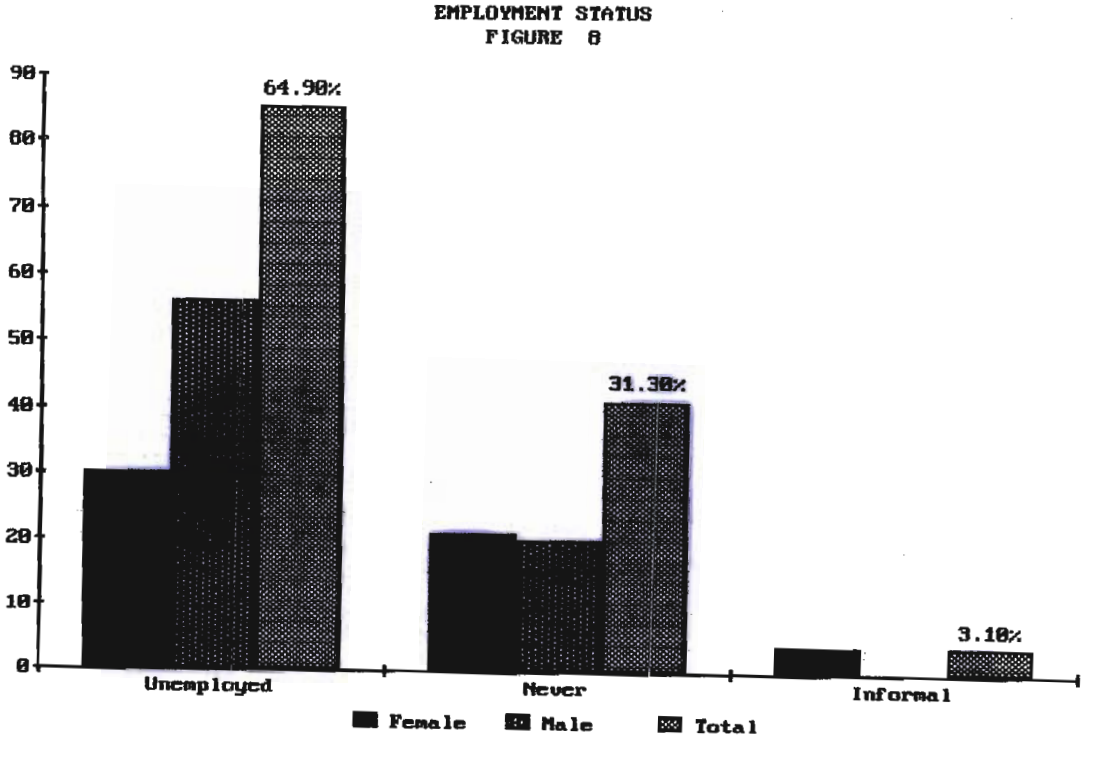
One male's renewal of the grant was deferred as he had no past records of his illness. The other two applicant's grants were re-instated after much soul searching by the author. The poor social circumstances mitigated in their favour.

Most applicants 100 (75,2%) were functionally illiterate ie. had less than a standard three educational level. Only one applicant had passed matric.The only applicant with a post matric qualification was a medically boarded teacher who had severe emphysema.

EDUCATIONAL LEVEL
FIGURE 7

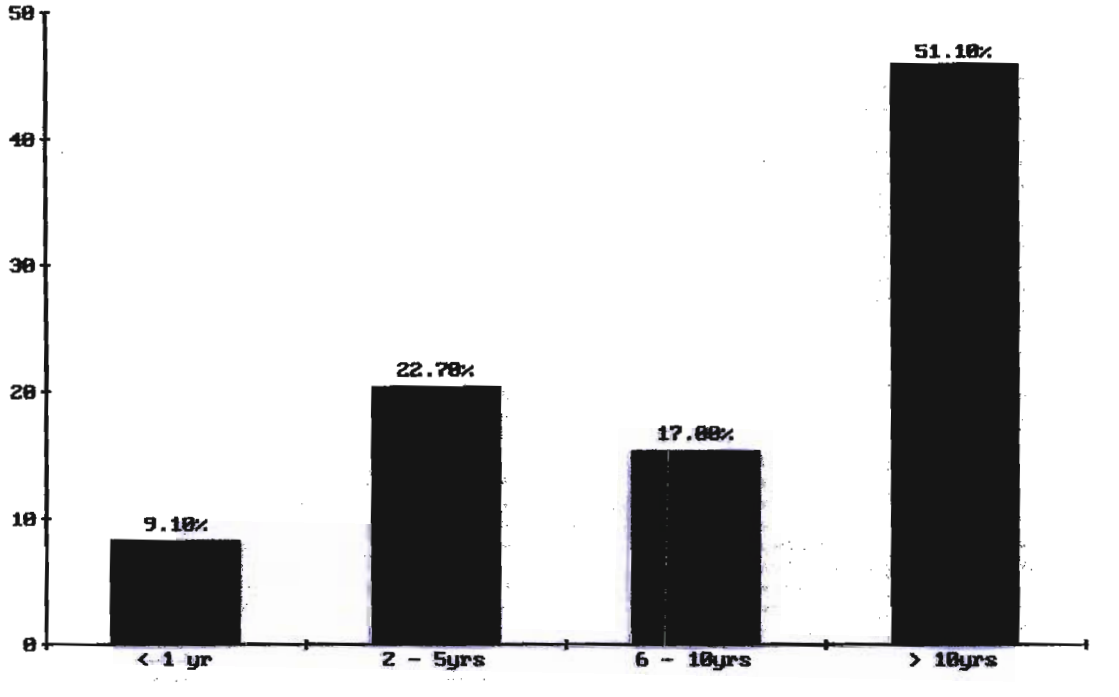


88 (64,9%) applicants were unemployed. 41(31,3%) had never been employed in the past. Only 4 (3,1%) were employed in the informal sector.

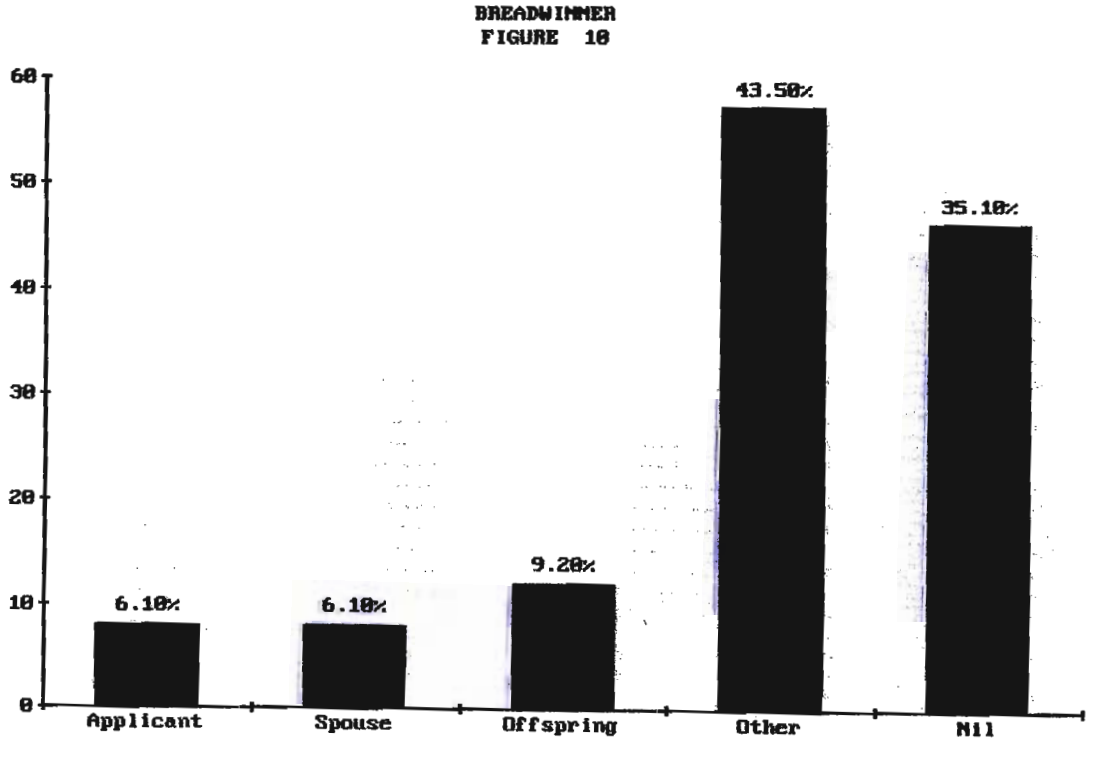


Of the unemployed, 45 (51,1%) had been unemployed for more than 10yrs, followed by the 2 - 5yrs unemployment period with 20 (22,7%).

UNEMPLOYMENT STATUS
FIGURE 9

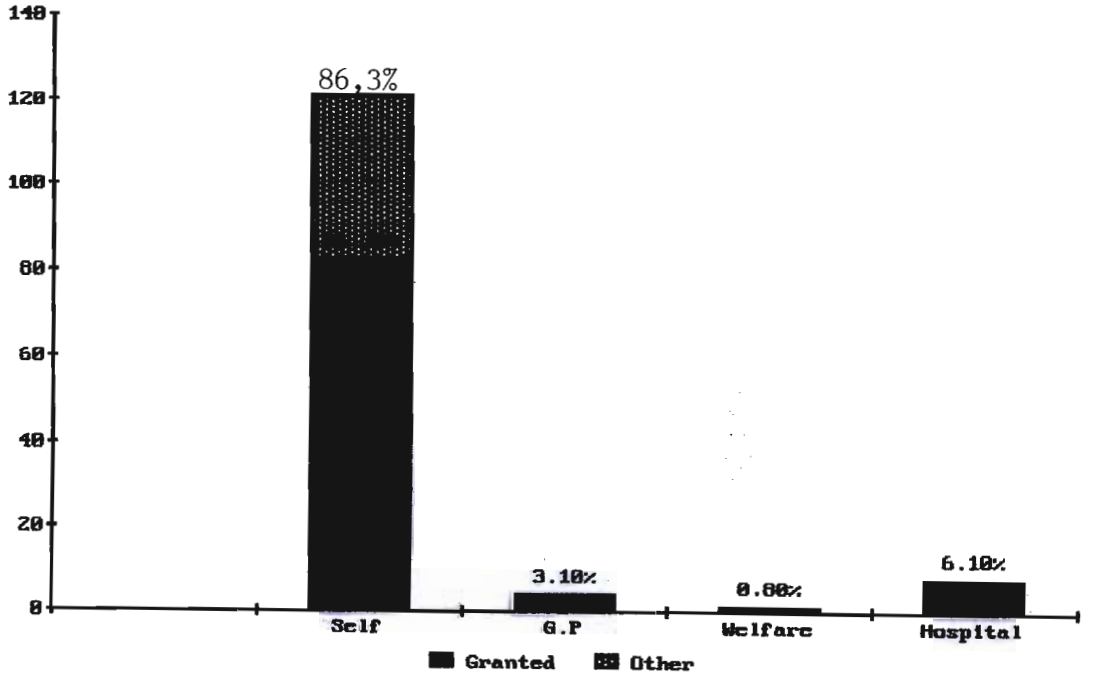


There was no breadwinner as such in most households 57 (43,5%). Help in the form of hand outs from relatives who are mainly old age pensioners provided some semblance of material assistance to this group . 46 applicants (35,1%) claimed to have had no form of breadwinner whatsoever.



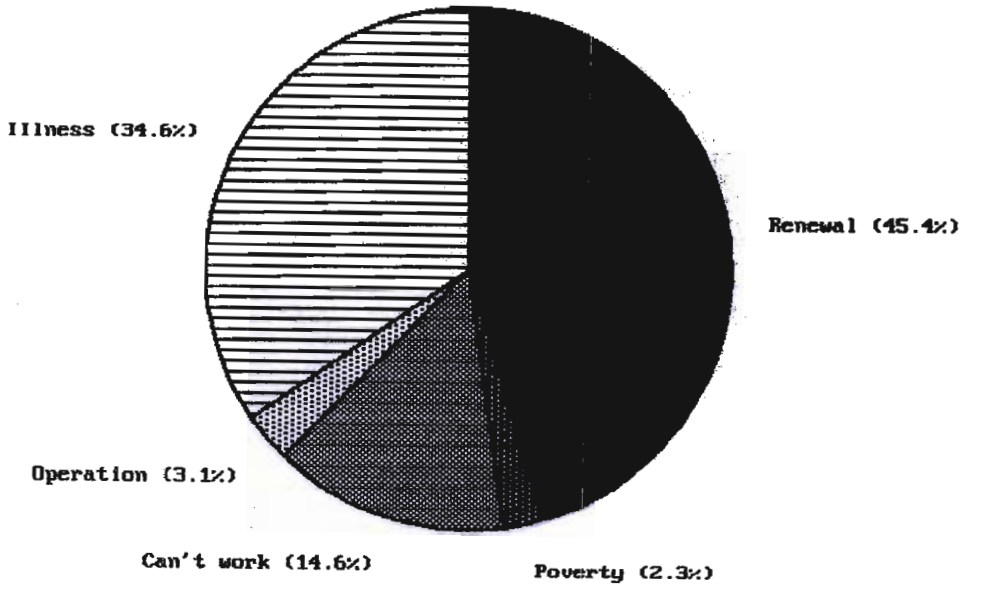
By far the majority of applicants were self referred 77 (86,3%). Most other applicants were referred by State hospitals. As predicted, all referred persons by Health professionals and Welfare departments were awarded grants as compared to 70,1% of self referred persons.

SOURCE OF REFERRAL vs GRANT OUTCOME
FIGURE 11

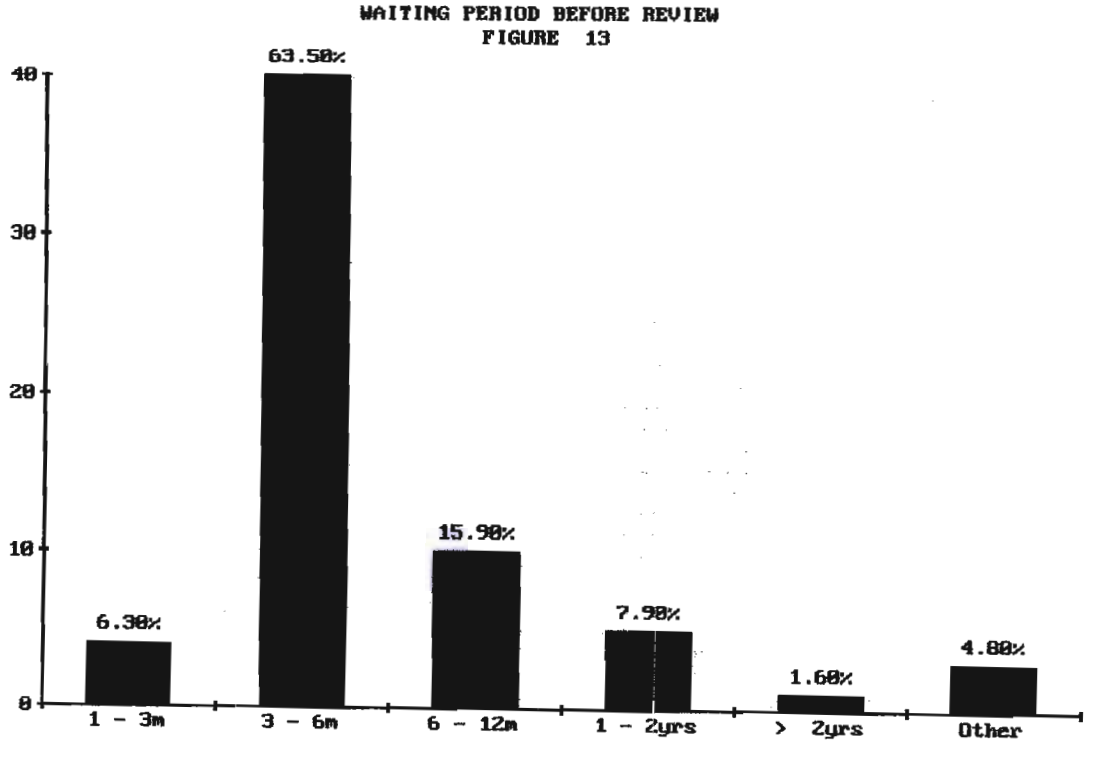


The reason for applying was in most cases for renewal of lapsed grants 59 (45,4%) and second commonest was for 'illness' 45(34,6%)

REASON FOR APPLYING
FIGURE 12

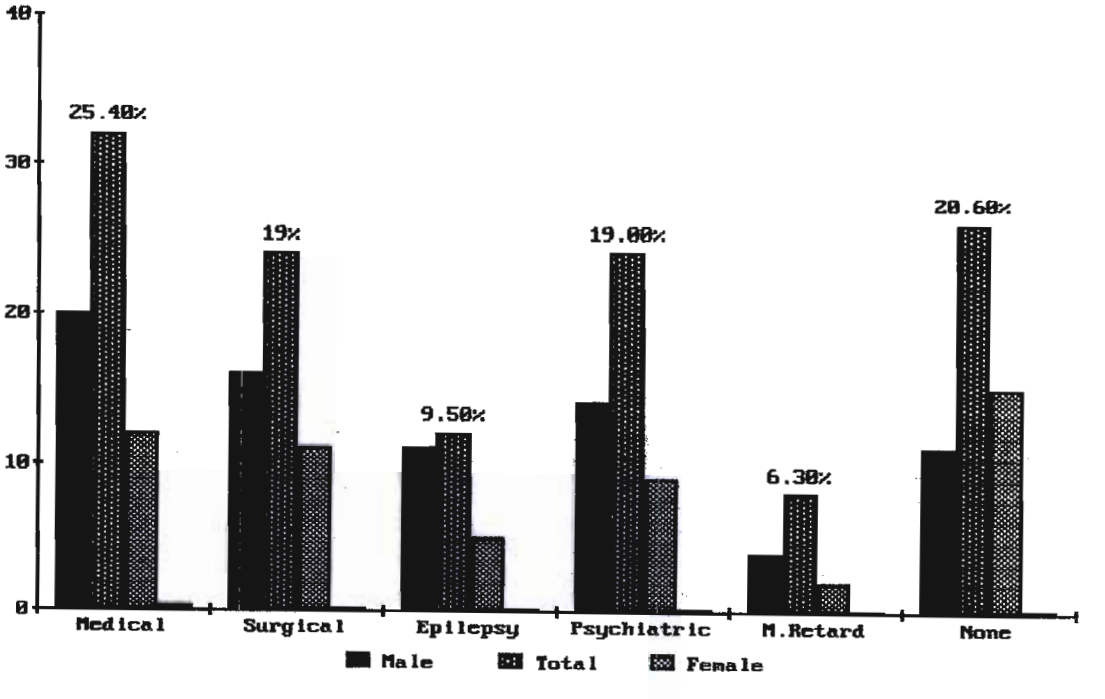


The majority, 40 (63,5%) of those who came for renewal had been without a grant for a period of 3 - 6 months. Interestingly, 3 of them were still receiving their grants and prudently came in anticipation of a possible suspension.



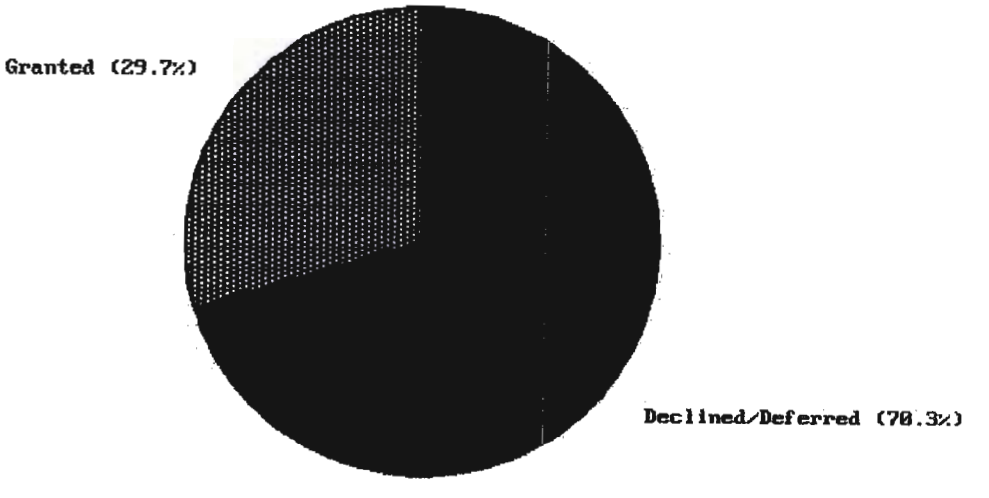
Most of the applicants had medical disability 32 (25,4%) with a suprisingly high frequency of applicants without any certifiable disability 27 (20,6%). Psychiatric problems (epilepsy, psychiatric illness, mental retardation) predominate as a group 45 (34,8%).

DISABILITY vs GENDER
FIGURE 14



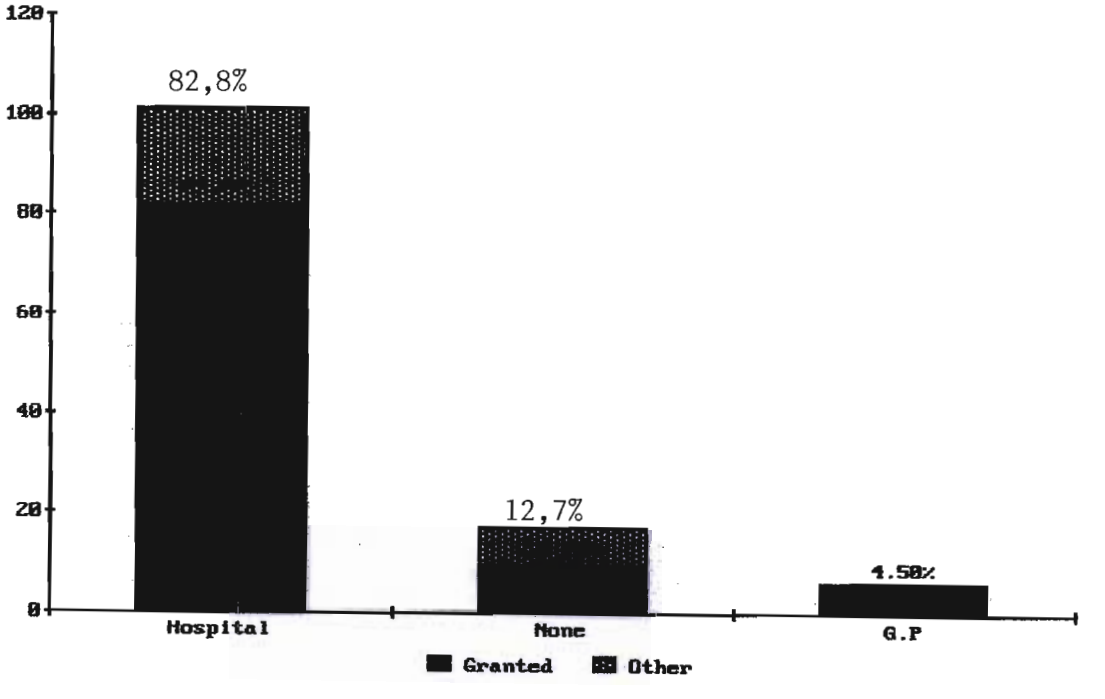
11 (29,7%) applicants assessed as without a certifiable disability were awarded a disability grant. This was invariably a compassionate grant as virtually no consistent social relief scheme is available in this area.

NO DISABILITY vs GRANT OUTCOME
FIGURE 15



Past medical records were a home based hospital record in 111 (82,8%) of applicants and only 6 (4,5%) from family practitioners. 17 (12,7%) applicants had no medical records whatsoever.The majority of applicants with medical records were awarded grants with 83% for general practitioner records and 73% for hospital records as compared to 52% for those without medical records.

MEDICAL RECORDS vs GRANT OUTCOME
FIGURE 16



(Other= declined or deferred)

CLINICAL ASSESSMENT

A disease - orientated assessment was done. The top five diagnoses made were:

(1) Epilepsy = 20 (14,2%)
(2) Chronic schizophrenia = 18 (13,4%)
(3) Mental Retardation = 15 (11,2%)
(4) Previous trauma = 12 (9%)
(5) Other Psychoses =9 (6,7%)

It is significant that psychiatric problems predominate in this group. Other diagnoses did not occur in significant numbers to warrant inclusion in this group.

DISEASE PROFILE DURING STUDY PERIOD

TABLES

1.SURGICAL

ASSESSMENT	FREQUENCY	PERCENTAGE
1.1 Surgical/Orthopaedic	12	9,0%
1.2 Paraplegia	2	1,5%
1.3 Hemiplegia	5	3,7%
1.4 Monoparalysis	4	3,0%
1.5 Post surgical procedure	6	4,5%
1.6 Arthritis	3	2,2%
1.7 Ostearthritis	6	4,5%
1.8 Plantar warts	2	1,5%
1.9 Goitre	1	0,7%

2. PSYCHIATRY

2.1 Mental retardation	15	11,2%
2.2 Epilepsy	20	14,9%
2.3 Chronic schizophrenia	18	13,4%
2.4 Other psychoses	9	6,7%
2.5 Parkinsonism	3	2,2%
2.6 Neurosis	1	0,7%
2.7 Cerebral palsy	1	0,7%
2.8 Downs syndrome	1	0,7%
2.9 Chronic alcoholism	2	1,5%

3. SENSORY DISABILITY

3.1 Deafness	2	1,5%
3.2 Poor vision	4	3,0%

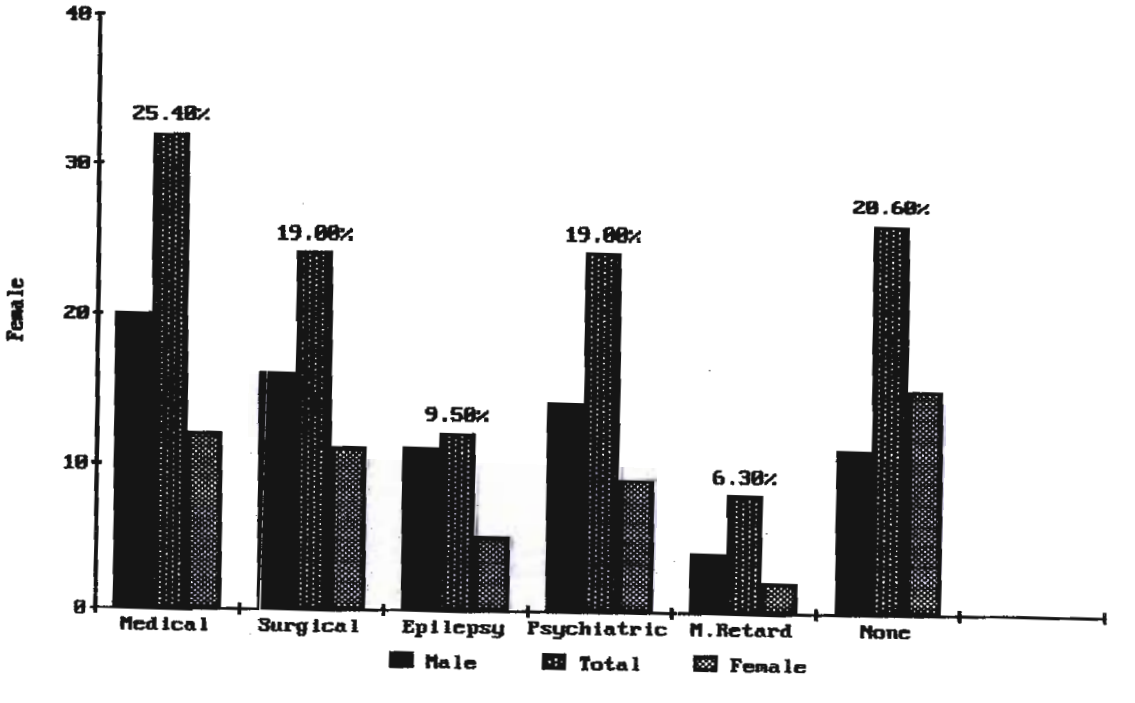
4.CHRONIC ILLNESS

ASSESSMENT	FREQUENCY	PERCENTAGE
4.1 CARDIOVASCULAR SYSTEM		
4.1.1 2nd degree Heart block	4	3,0%
4.1.2 Post Mitral valve replacement	1	0,7%
4.1.3 Cardiomyopathy	1	0,7%
4.1.4 Cor pulmonale	1	0,7%
4.2 TUBERCULOSIS		
4.2.1 Pulmonary Tuberculosis	3	2,2%
4.2.2 Tuberculous pericarditis	1	0,7%
4.2.3 Tuberculosis of the spine	1	0,7%
4.3 Gross obesity	3	2,2%
4.4 Diabetes Mellitus	3	2,2%
4.5 Asthma	3	2,2%
4.6 Hypertension	9	6,7%
4.7 HIV infection	2	1,5%
4.8 Chronic obstructive pulmonary disease	5	3,7%
4.9 Destructive lung disease	4	3,0%
4.10 Leprosy	1	0,7%
4.11 Malnutrition	1	0,7%
MISCELLANEOUS		
5.1 Illness (ill defined)	4	3.0%
5.2 Musculoskeletal pain	3	2,2%
5.3 Problem of living	8	6.0%
5.4 Pensionable age	1	0.7%

DISABILITY ASSESSMENT

The most frequent disability found was medical in 32 of cases (25,4%) followed by surgical 24 (19%) and psychiatric 24 (19%). It is significant that no disability was found in 26 cases (20.6%)!

DISABILITY vs GENDER
FIGURE 17

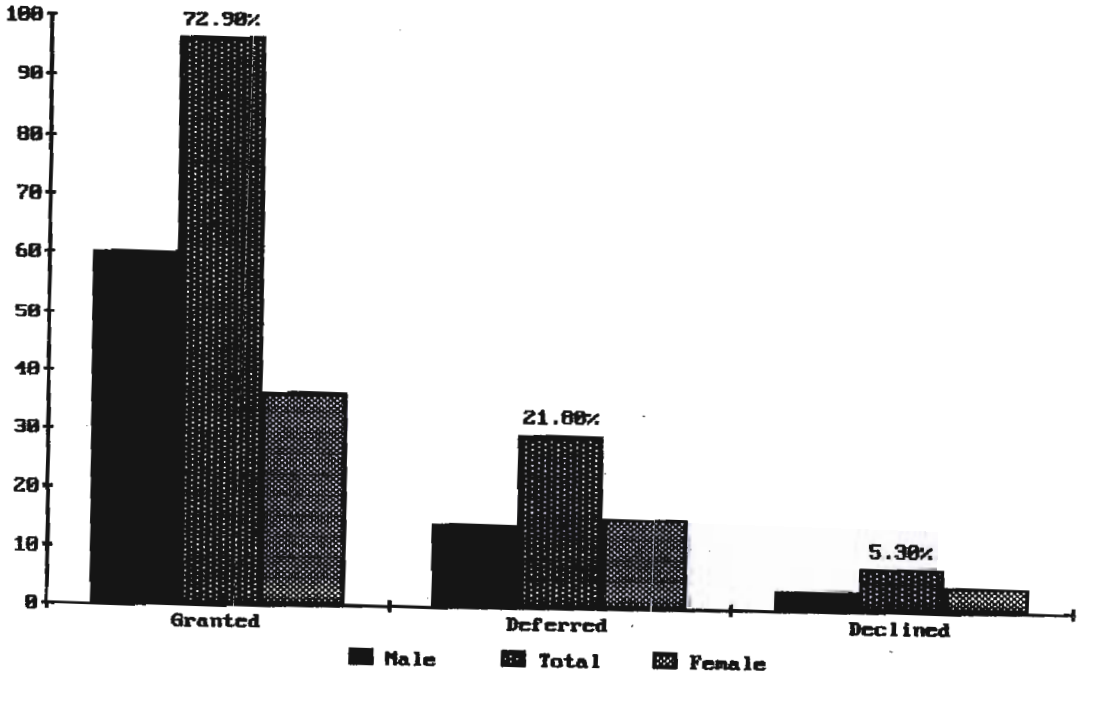


RESULTS OF APPLICATIONS

97 (72,9%) of applicants were awarded disability grants. 7 (5,3%) were declined and 29 (21,8%) were deferred. Of the deferred group, 2 (1,5%) were subsequently awarded grants. 2 (1,5%) applicants with HIV, a disease of conscience, were awarded disability grants even though they were both only at the progessive generalised lymphadenopathy stage. This in future will form a large portion of applicants for disability grants. Applicants with more than one illness, especially psychiatric illness tended to improve the chances of them being awarded a grant eg. epilepsy and mental retardation. 5 (10%) applicants had both epilepsy and mental retardation and 1 (3,1%) both psychiatric illness and epilepsy. All were awarded disability grants.

A stable post mitral valve replacement patient came with a note from the Cardiology Clinic requesting the District Surgeon to recommend a disability grant to enable the patient to travel to Johannesburg for regular reviews. Although there was no certifiable disability as such, a grant was awarded for social reasons.

RESULT OF APPLICATION vs GENDER
FIGURE 18



DISCUSSION

The study involved 134 subjects with a male to female ratio of 6:4. Most of these applicants came from the greater Nqutu area (78,9%). There was a preponderance of males in all age groups with the majority of applicants coming from the above 50yrs age group with a frequency of 32,8%.

The majority of applicants were married (41,4%) followed by a large singles group (37,6%). 64% of the single applicants had a significant psychiatric problem which qualified them for a disability grant. 81,3% of the widowed group were females. Most of these widows had never worked in the past.

The problem of poverty is well illustrated by the high unemployment rate of 96,2%. Only 3,1% of subjects were employed in the informal sector. 90,8% of applicants had been unemployed for more than 2yrs. 51,1% of applicants had been unemployed for more than 10yrs. 31,3% of applicants had never been employed in the past. 35,1% of the applicants claimed to have had no breadwinners at all. 52,7% of applicants depended on the extended family structure for their survival. 71,7% of applicants had 1 or more dependants.

75,2% of applicants were functionally illiterate having had no more than 4 years of schooling. The problem of scholars presenting for disability grants is contentious as the Pensions Act makes provision only for "persons who are unable to engage in meaningful employment owing to physical or mental disability"[1]! As children at school, they would normally be still dependent on their parents for their every day needs and their "disability" at this stage should not be an issue. 3 such scholars were seen during the study period and 2 of them were subsequently awarded "disability grants" to enable them to continue with their education. This decision was largely influenced by the abject poverty of their families.

45,4% of applicants had presented for a review of their grants. 63,5% of these applicants had been without a grant for a period of 3-6 months. 4% of review applicants had prudently "arranged" their own reviews in an effort to pre-empt a possible suspension of their grants!

34,6% of applicants offered "illness" as their reason for applying for a grant. 3,1% offered "operation" as their reason for applying. 14,6% applied because they "could not work". The majority of the latter group were widows. 2,3% of applicants offered "poverty" as a reason for applying.

Psychiatric problems took 4 places out of 5 top diagnoses made. Epilepsy was the most frequent diagnosis made with 14,2%, followed by chronic schizophrenia (13,4%),mental retardation (11,2%), previous trauma (9%) and other psychoses with (6,7%).

Significant disability was found in 79,4% of applicants. The most common disability was for medical problems (25,4%) followed by surgical and psychiatric illness each with 19% respectively. Epilepsy was responsible for 9,5% and mental retardation for 6,3% . It is significant that 20,6% of applicants had no certifiable disability at all.

A total of 74,4% of applicants were awarded disability grants during the study period. 66,2% of these were awarded for genuine disability and 8,2% for social or compassionate reasons as explained in the following paragraph. 5,3% of applications were declined and 20,3% were deferred. The deferred applicants were either requested to provide more details of their personal or medical records or referred to specialist clinics for further appraisal.

Social factors frequently influenced the decision to award a disability grant to an applicant. A stable post mitral valve replacement applicant with no apparent disability was awarded a grant mainly to enable her to cover travelling expenses to a cardiac clinic in Johannesburg. 2 HIV positive patients were also awarded grants even though they did not satisfy the criteria of "inability to work". All applicants on pulmonary tuberculosis therapy were given a one year temporary grant to allow them to enjoy full recovery. 29,7% of applicants with no certifiable disability were awarded grants on compassionate grounds. As already stated, this was done because no consistent social relief scheme is available in this area.

Past medical records were invaluable in assessing disability in applicants with chronic illnesses or physical disability. It was thus easier to assess the efficacy of epileptic therapy in applicants with medical records, for example. The home-based system of medical records proved to be invaluable especially in a community with a high illiteracy rate.

Temporary grants were awarded to poorly controlled chronic manageable diseases like epilepsy, asthma, diabetes and hypertension. Poor control of these illnesses resulted in incapacity and rendered the applicants unable to hold jobs for any length of time[7]. 82% of applicants had a home-based record from the hospital, and 4,5% of applicants had a home-based record from their general practitioner. 12,7% had no medical records whatsoever. 83% of applicants with general practitioner records were awarded grants and 73% of applicants with hospital records were awarded grants. Only 52% of applicants without any medical records were awarded disability grants.

Applicants who had multiple medical problems were awarded grants as the cumulative effect tended to increase their incapacity. 10% of applicants had both epilepsy and mental retardation, and 3,1% had both psychiatric illness and epilepsy. They were all awarded disability grants.

Administrative problems encountered were a high frequency of requests for reviews(45,4%). This invariably caused much hardship to needy persons and resulted in ingenuity as shown by 4% of review applicants who pre-empted the suspension of their grants by arranging for their own reviews.

The Pensions Officers' casual attitude to disability grant applications is demonstrated by their seldom application of the Means Test[1]. We thus had a medically boarded teacher on full pension also applying for a disability grant. The problem of scholars applying for disability grants has already been alluded to.

CONCLUSION

Family Physicians by the very nature of their training, dare not separate disease or ill health conceptually from the person nor the person from his or her environment [3,4,5,11]. It is therefore evident that a purely clinical (biomedical) model in assessing disability that seeks to ignore the person's perception of his or her "disability" as well as the contextual factors at play is neither practical nor desirable. No single guide to assess disability can therefore be expected to be 100% accurate[4]. A holistic approach that seeks to individualise an applicant's disability assessment will prove to be the most realistic and desirable approach.

The Social Relief Scheme as envisaged by the Pensions Act[1] is seldom available to needy persons in KwaZulu. As stated in the "Natrass Report" of November 1985[2,10], District Surgeons should not be expected to recommmed "disability grants" on compassionate grounds only. This, however, must go hand in hand with a comprehensive and sustainable Social Relief Scheme which is presently not readily available in places like Nqutu.

The parlous state of State Health Services in areas like Nqutu, results in sub-optimal control of chronic manageable diseases like epilepsy[7], asthma, hypertension and diabetes mellitus. Awarding temporary disability grants to such patients results in the "dependency syndrome" and in most cases they invariably expect their grants to be renewed every year. It should, however, be remembered that "whilst treatment is viewed as a 'ticket' to normality in some communities, in poor communities it is frequently viewed as a 'ticket' to survival in the form of a disability grant"[5]. At the present moment, there is no incentive for poor people to get well!

The administration of the Pensions Offices leaves much to be desired as initial screening as envisaged by the Pensions Act is seldom applied. It is therefore not suprising that we have a high rate of unnecessary requests for reviews, even for persons who are still receiving their disability grants! The application of a disability grant by a medically boarded teacher is also a case in point.

RECOMMENDATIONS

District Surgeons should not be used to prop up deficiencies in the implementation of the Social Relief Schemes. A comprehensive and sustainable Social Pensions Scheme should be put in place as a matter of urgency to assist needy but non disabled persons. This should be done, in the interim, under the aegis of the Reconstruction and Development Programme.

The restructuring of the Pensions Offices must include re-training of Pensions Officers and the inculcation of a more committed and caring approach to their work. It should also include a review of all Social Pensions to weed out persons who do not satisfy the Means Test[1]. A centrally controlled Social Pensions Scheme which will be provincially administered will ensure equity in social benefits to all communities.

Ultimately, the "reconstruction and development" of underprivileged communities like Nqutu should target the pervasive illiteracy, high unemployment rate, poverty and the parlous condition of state health services in order to uplift these communities and consequently improve their self sufficiency.

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KWAZULU GOVERNMENT SERVICE

ZWP 7

MEDICAL REPORT : DISABILITY PENSION APPLICATION

N.B. (A) THIS REPORT MUST BE PERSONALLY COMPLETED AND SIGNED BY A DISTRICT SURGEON OR GOVERNMENT MEDICAL OFFICER ONLY.
(B) PLEASE COMPLETE IN DUPLICATE, PLACING CARBON TO ENSURE ORIGINAL SCRIPT ON BOTH SIDES OF THE REPORT.
(C) PLEASE COMPLETE EACH SECTION AS STIPULATED, IN ACCORDANCE WITH GUIDELINES ISSUED BY THE DEPT. OF HEALTH, KWAZULU.

PERSONAL PARTICULARS IN APPLICANTS IDENTITY DOCUMENT

Surname _____

First names _____

Identity No. _____
(No alteration to the number will be accepted.)

Sex _____ Estimated Age _____

Signed _____

Right thumbprint

Magistrate _____ District

Date stamp

1. HISTORY OF PRESENT COMPLAINTS OR ABNORMALITIES
(This must include duration of complaints and dates of relevant events.)

2. CLINICAL FINDINGS AND DIAGNOSIS
(This must include appropriate physical signs (plus X-ray or other reports) which support the diagnosis and indicate the extent of any morbid process or degree of abnormality.)

B.P. reading _____ Apparent age _____ Is he/she overweight? _____

3. NATURE AND DEGREE OF FUNCTIONAL IMPAIRMENT
(In what manner does the physical or mental abnormality interfere with normal daily activities? [If episodic, state frequency].)

4. DISABILITY

(a) **In your opinion does the nature and degree of the physical or mental abnormality described totally** disable the person:

* for remunerative work? Yes ☐ No ☐

* to handle financial affairs? Yes ☐ No ☐

(b) **If totally disabled is this permanent?** Yes ☐ No ☐

(c) **If not permanently disabled state likely duration of disability:**

6 mths ☐ 1yr ☐ 2yrs ☐ Longer ☐

(d) **Is review indicated?** Yes ☐ No ☐ 6mths ☐ 1yr ☐ 2yrs ☐ Longer ☐

(e) **If not totally disabled, for what work do you consider the applicant is fit?**

_____

(f) If a housewife, is she able to carry out her housework? _____

5. MEDICAL TREATMENT

(a) Please give details of any previous hospital or treatment or investigation **relating to the above complaint (s).** (This should include place, date and results).

(b) Is the patient currently under medical care?

If yes, — Where, and for how long? _____

What treatment? _____

Is it effective? _____

(c) If not under treatment (or not effectively under treatment) would medical or surgical treatment cure or improve the disability? Yes ☐ No ☐

If yes, — What treatment is recommended) _____

6. CERTIFICATION

I certify that I have checked that the personal identification document produced by the applicant belongs to him/her and that his/her personal particulars are entered on this medical report.

Place _____ Signature _____

Date _____ Name in block letters _____

Designation (District Surgeon/Govt. Med. Officer) _____

Address _____

For official use only:

GROUP GRAPHICS C.C.

MEDIESE BEAMPTE SE EVALUASIE/MEDICAL OFFICER'S EVALUATION
oor graad van gestremdheid/concerning degree of disability

(a) **Is gestremdheid/Is disability**
Permanent/Permanent.....
Tydelik/Temporary .....Tydperk/Period .....

(b) **Na wie verwys moet word vir verdere evaluasie/behandeling** (byvoorbeeld geneesheer/spesialis, arbeidsterapeut, fisioterapeut, oogarts, psigiater/kliniese sielkundige, ens.)
To whom be referred for further evaluation/treatment (eg. doctor/specialist, occupational therapist, physiotherapist, opthalmologist, etc)
.....
.....

(c) **Sal die pasiënt baat vind by verdere behandeling?**
Will the patient benefit from further treatment?
.....
.....

(d) **Mediese beampte se aanduiding op onderstaande skaal of aansoeker op grond van sy liggaams- of geestesgebreke onbekwaam is om uit hoofde van 'n diens, betrekking of beroep die middele te verkry wat nodig is om hom in staat te stel om in sy onderhoud te voorsien.**
Indication by Medical Officer according to the scale below whether the applicant is capable, owing to his mental or physical disability, unfit to obtain by virtue of any service, employment or profession the means needed to enable him to provide for his maintenance.

0 1 2 3 4 5

* (Mediese Beampte moet die inligting soos in **paragraaf A verstrek**, in aanmerking neem/Medical Officer must take information furnished in **paragraph A into consideration.**)

HANDTEKENING VAN MEDIESE BEAMPTE .....
SIGNATURE OF MEDICAL OFFICER
NAME (DRUKSRIF)/NAME (PRINT) .....

PLEK/PLACE ..... **DATUM/DATE** .....

C. **Moet deur die Direkteur-generaal of sy gemagtigde voltooi en geteken word**
To be completed and signed by the Director-general or authorised officer

MERK MET 'N X WAAR VAN TOEPASSING/MARK WITH AN X WHERE APPLICABLE

Graad van gestremdheid: **Degree of disability:** Permanent: Permanent:		Tydelik: Temporary:		Tydperk: Period:	

Nie gestremd: Not disabled:		**Voordeel goedgekeur / afgekeur** **Grant approved / not approved**	

.....
HANDTEKENING/SIGNATURE

.....
RANG/RANK

.....
DATUM/DATE

NPA

MEDIESE VERSLAG: TOELAE VIR GESTREMDE
MEDICAL REPORT: GRANT: DISABLED PERSON

A. Moet deur **beampte** voltooi word
To be completed by **official**

Vorm A
Form

NAAM VAN AANSOEKER ..... **OUDERDOM** .....
NAME OF APPLICANT **AGE**

ID NO. ..... **GESLAG** .....
ID NO **SEX**

OPLEIDING/TRAINING .....

BEROEP/OCCUPATION .....

DATUM VAN ONTSLAG: WERK .....
DATE OF DISCHARGE: EMPLOYMENT

B. Moet deur **Mediese Beampte** voltooi en onderteken word
To be completed and signed by **Medical Officer**

SKAAL/SCALE (Omkring toepaslike syfer/Circle appropriate number)

0 - **GEEN** funksie/**NO** function
1 - **BAIE ERGE** funksionele inkorting/**VERY SERIOUS** functional curtailment
2 - **ERGE** funksionele inkorting/**SERIOUS** functional curtailment
3 - **MATIGE** funksionele inkorting/**MODERATE** functional curtailment
4 - **GERINGE** funksionele inkorting/**SLIGHT** functional curtailment
5 - **NORMAAL/NORMAL**

B1. ENERGIE/ENERGY

a) Kardiovaskulêr/Cardiovascular	0	1	2	3	4	5
b) Respiratories/Respiratory	0	1	2	3	4	5
c) Diverse/Miscelaneous(HB, Endocrones, Thyroid, Food-too much too little)	0	1	2	3	4	5

B2. KONTROLE/CONTROL

a) Motoriese beheer/Motor control.....	0	1	2	3	4	5
b) Sensoriese beheer/Sensorial control..	0	1	2	3	4	5
c) Gesig/Sight	0	1	2	3	4	5
d) Gehoor/Hearing.....	0	1	2	3	4	5

SPESIFISEER/SPECIFY
.....
.....
.....
.....

e) Begripsvermoë/Intelligence.....	0	1	2	3	4	5
f) Geestestoestand/Mental condition.....	0	1	2	3	4	5
g) Epilepsie/Epilepsy	0	1	2	3	4	5
h) Toevalle/Seizures.....	0	1	2	3	4	5

B3. MEGANIKA/MECHANICS:

a) Werwelkolom/Vertebrata.....	0	1	2	3	4	5
b) Boonste ledemate/Upper limbs	0	1	2	3	4	5
c) Onderste ledemate/Lower limbs	0	1	2	3	4	5