

Mental Health Questionnaire

(To be completed by the medical attendant)

Please return this completed form with any relevant copies to ds_uwrequirements@hollard.co.za.

1. Life insured's details

Policy no. _____ Identity no. _____

Name of insured _____

1.1 When did the symptoms of the patient's condition first occur? State month, year and duration

1.2 What were the symptoms?

a. Physical, e.g. weight loss, loss of appetite, fast pulse, stomach trouble

b. Mental, e.g. insomnia, anxiety, worry, depression

1.3 When did the symptoms last occur?

D	D	M	M	Y	Y	Y	Y
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1.4 In your opinion, what caused the condition and relapses? _____

1.5 What was the final diagnosis made by you? _____

1.6 What treatment/type of medication is he/she currently taking? State dosage of medication and type of other treatment(s) if applicable

1.7 Is the patient compliant with treatment? YES ☐ NO ☐

1.8 What treatment/medication did he/she receive in the past? State dosage and type of medication and type of other treatment(s) if applicable

1.9 For how long has the patient been on treatment/medication? _____

1.10 Has he/she ever been absent from work as a result of his/her condition? YES ☐ NO ☐

If YES, confirm dates and for how long? _____

1.11 Has he/she ever been hospitalised? YES ☐ NO ☐

If YES, please provide details _____

Initials

1.12 Is there anyone in the patient's family who suffers from a nervous or mental condition? YES ☐ NO ☐
If YES, give details

1.13 Has the patient ever attempted suicide? YES ☐ NO ☐
If YES, give details

1.14 Has the patient undergone any special examinations, tests or investigations? YES ☐ NO ☐
If YES, give details and results

1.15 Has the patient had or ever experienced any alcohol or other substance abuse or addiction? YES ☐ NO ☐
Provide details

1.16 Is he/she completely cured and has he/she fully recovered? YES ☐ NO ☐
Provide details

1.17 Give the name(s) and address(es) of the doctor(s) and other specialists who have treated the patient

1.8 Is there any other information pertaining to the patient that may be relevant? YES ☐ NO ☐
Provide details

Initials

2. Notice to medical attendants

Hollard Life will reimburse all medical accounts issued according to the insurance billing code A1403 (General practitioner) , A1450 (Specialist).

Full name _____

Qualifications _____ Practice no. _____

Work tel. no. _____ Cell no. _____

Email address _____

Postal address _____

Please send your account to ds.doctoraccount@hollard.co.za.

3. Declaration by medical attendant

I declare that the statements above are true and complete.

Signature
(medical attendant) _____

Date

D	D	M	M	Y	Y	Y	Y
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Hollard Declaration

We respect and adhere to patient confidentiality and data privacy principles in relation to Personal Information. We will therefore only process this information for the purpose for which it is intended.