**Medical Report**

*This template can be used as a guide for you and your doctor to outline the medical details related to your disability. This will generally need to be completed at an appointment, and you should let the practice know at the time of booking that you need the doctor’s assistance to complete a Medical Report for a Disability Support Pension application.*

**Applicant’s Details**

Full Name ­­­­­­­­­­­­

Centrelink Ref Number

Date of Birth

Address

Phone Number

**Doctor’s Details**

Full Name

Qualifications

Medical Practice

Address

Phone Number

**Patient Relationship**

The applicant has been my patient since

and has been a patient at this practice since

**Medical Details**

1. Does the patient have a medical condition that may significantly reduce their life expectancy?

[ ]  No

[ ]  Yes

Diagnosis:

1. Is the average life expectancy of a person with this condition shorter than 24 months?

[ ]  No

[ ]  Yes

1. Does the patient have one or more medical conditions that have a significant impact on their ability to function?

*(e.g. ability to perform daily activities, self-care, endurance, movement/dexterity (walking, bending, sitting, standing, lifting/carrying/handling and manipulating objects), neurological/cognitive function (concentration, attention, decision making, memory, problem solving), behaviour, planning, interpersonal relationships, sensory function (hearing, vision, speaking, smell), digestive, reproductive, continence function, functions of consciousness (involuntary loss of or altered consciousness (e.g. seizures, migraines))*

[ ]  No

[ ]  Yes, how many?

**Condition Information**

On the following pages, give details about the conditions that have a significant impact on the patient’s ability to function.

List the conditions in order of degree of impact on ability to function, starting with the condition with the most impact.

Condition One

1. Diagnosis:
2. Date of Onset (if known):
3. The diagnosis is:

[ ]  presumptive

Are further investigations/tests planned to confirm the diagnosis?

[ ]  Yes

[ ]  No

[ ]  confirmed

Date of Diagnosis:

Is the diagnosis supported by further specialist opinion?

[ ]  No

[ ]  Yes,

Are the relevant specialist reports available?

[ ]  No

[ ]  Yes

[ ]  attached

[ ]  will provide on request

1. Provide details of all **current treatment** for this condition (e.g. hospitalisation, surgery, medication and dosage, counselling, physical therapy, rehabilitation, frequency of treatment)

1. Provide details of **past treatment** for this condition (e.g. hospitalisation, surgery, medication and dosage, counselling, physical therapy, rehabilitation, frequency of treatment) including ceased treatment and the reason it stopped.

1. Have you or another doctor from your practice previously referred this patient to a **specialist/consultant**?

[ ]  No, because

[ ]  Yes,

1. Provide details of any further **scheduled or proposed treatment** with estimates of likely dates of commencement and expected duration and whether it would impact their work capacity.

1. The patient’s compliance with recommended treatment has been:

[ ]  very compliant

[ ]  usually compliant

[ ]  rarely compliant

[ ]  uncertain

Provide details of any issues related to accessing or undertaking suitable (reasonable) treatment, including referrals to specialists and wait times.

1. Describe the patient’s current symptoms and impairments. Be specific and include details about severity, frequency and durations.

Note: symptoms are those persisting despite treatment, aids, equipment or assistive technology.

1. Provide details of **underlying causes and contributing factors**, results and dates of investigations/procedures and specialist consultations (e.g. radiology, pathology, RFTs, specialist reports)

1. Does this impact on the patient’s:

[ ]  ability to perform daily activities

[ ]  self-care

[ ]  endurance

[ ]  movement/dexterity (walking, bending, sitting, standing, lifting/carrying/handling and manipulating objects)

[ ]  neurological/cognitive function (concentration, attention, decision making, memory, problem solving)

[ ]  behaviour, planning, interpersonal relationships

[ ]  sensory function (hearing, vision, speaking, smell)

[ ]  digestive, reproductive, continence function

[ ]  functions of consciousness (involuntary loss of or altered consciousness (e.g. seizures, migraines))

[ ]  other:

Details about how this condition and its treatment currently impact on the patient’s ability to functions. Be specific.

1. Impact of this condition on the patient’s ability to function is expected to persist for (required for eligibility):

[ ]  Less than 3 months

[ ]  3-12 months

[ ]  13-24 months

[ ]  More than 24 months

1. Within the next 2 years the effect of this condition on the patient’s ability to function is expected to:

*\*For additional conditions that have had a significant impact on the patient’s ability to function, extra pages are included at the end which can be copied as many times as necessary to answer the questions for each of the patient’s other conditions and then attached to the end of this document.*

1. Does this patient have any other medical conditions that are generally well managed and that cause minimal or limited impact on their ability to function?

[ ]  No

[ ]  Yes,

1. Is there any other information that you would like to provide?

[ ]  No

[ ]  Yes,

**Signed by Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Doctor:**

Condition      :

1. Diagnosis:
2. Date of Onset (if known):
3. The diagnosis is:

[ ]  presumptive

Are further investigations/tests planned to confirm the diagnosis?

[ ]  Yes

[ ]  No

[ ]  confirmed

Date of Diagnosis:

Is the diagnosis supported by further specialist opinion?

[ ]  No

[ ]  Yes,

Are the relevant specialist reports available?

[ ]  No

[ ]  Yes

[ ]  attached

[ ]  will provide on request

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1. Provide details of **past treatment** for this condition (e.g. hospitalisation, surgery, medication and dosage, counselling, physical therapy, rehabilitation, frequency of treatment) including ceased treatment and the reason it stopped.

1. Have you or another doctor from your practice previously referred this patient to a **specialist/consultant**?

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Note: symptoms are those persisting despite treatment, aids, equipment or assistive technology.

1. Provide details of **underlying causes and contributing factors**, results and dates of investigations/procedures and specialist consultations (e.g. radiology, pathology, RFTs, specialist reports)

1. Does this impact on the patient’s:

[ ]  ability to perform daily activities

[ ]  self-care

[ ]  endurance

[ ]  movement/dexterity (walking, bending, sitting, standing, lifting/carrying/handling and manipulating objects)

[ ]  neurological/cognitive function (concentration, attention, decision making, memory, problem solving)

[ ]  behaviour, planning, interpersonal relationships

[ ]  sensory function (hearing, vision, speaking, smell)

[ ]  digestive, reproductive, continence function

[ ]  functions of consciousness (involuntary loss of or altered consciousness (e.g. seizures, migraines))

[ ]  other:

Details about how this condition and its treatment currently impact on the patient’s ability to functions. Be specific.

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1. Within the next 2 years the effect of this condition on the patient’s ability to function is expected to: