Print Form

GP Statement of Evidence

Patient details

Name

Address

Postcode

Date of Birth

Customer Centrelink Reference Number

Please complete and print **ONLY** the sections and pages relevant to your patient

Instructions for the patient

This report provides you with evidence when seeking funding for support from agencies such as the National Disability Insurance Scheme (NDIS).

What you should do:

Take this report with you when you visit your treating doctor. Please let your doctor know at the time of making the appointment that you will need **a long appointment** as you need this form to be completed. You will need to ensure you bring any notes or records of the following kind with you to your appointment:

- Assessments relating to your diagnosis of disability
- Support needs
- Disability specific devices or aids that you use
- Therapy or treatment plans from allied health professionals or other therapists

Does the patient meet the eligibility for the NDIS?

www.ndis.gov.au/people-disability/access-requirements.html

Privacy:

Your personal information is protected by law, including the Privacy Act 1988. Your treating doctor is required to abide by Australian privacy legislation. You should ensure that any agencies to which you deliver this report also abide by this legislation.

Instructions for the treating doctor

This report has been developed to assist patients with a disability and/or their families or advocates apply for funding through funding bodies such as the National Disability Insurance Agency (NDIA).

It is advised that this report be accompanied by other assessments such as:

- WHODAS (World Health Organisation Disability Assessment Schedule, utilising the Classification of Functioning, Disability and Health [ICF]) http://www.who.int/classifications/icf/whodasii/en/
- SIS (Supports Intensity Scale of AAIDD) http://aaidd.org/sis
- ICAP (Inventory for Client and Agency Planning) http://icaptool.com/

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It is also advised that prospective National Disability Insurance Scheme (NDIS) participants engage in pre-planning activities before attending a formal first meeting with an NDIS planner. These activities include seeking advice from a disability support or advocacy organisation, reading the materials available at the NDIS website (http://ndis.gov.au) and drafting the following materials before meeting with the NDIS planner:

- Participant statement: a statement of the person's current support arrangements
- Goals and priorities: a detailed analysis of the support needs associated with each of the NDIS domains (Daily Living, Home, Health and Wellbeing, Lifelong Learning, Work, Social and Community Participation, Relationship, Choice and Control)

Certification

This person has been...

My patient since:

Day Month Year

A patient at this practice since:

Day Month Year

Doctor's details and declaration.

Please make sure you have read the instructions on the first page of this form.

Please print in BLOCK LETTERS or use stamp.

Details of doctor completing this report:

Name

Qualifications

Address

State Postcode

Phone number

Signature

Day Month Year

Stamp (if applicable)

PART A – Developmental disability

1 Does the patient have any conditions which have a SIGNIFICANT impact on their ability to function (e.g. endurance, movement, cognitive function, communication, behaviour, ability for self care, need for support in activities of daily living)?

No ☐ Remove this section of the form and go to **PART B** Yes ☐ Give details below

Instructions for the doctor:

Please provide answers to the following questions based on clinical assessment, results of tests and investigations, and current scientific knowledge.

Self-reported symptoms alone are not sufficient.

Attach
- A report from the doctor or specialist doctor who usually treats this condition (if not you),
- Results of relevant test and investigation results (reports only), if available.

Diagnosis

2a What is the Developmental Disability? e.g. cognitive (e.g. Intellectual Disability), Autism, Motor (e.g. Cerebral Palsy).

2b What is the cause of the disability (if known)? e.g. Down Syndrome, Fragile X, Tuberose Sclerosis, Fetal Alcohol Syndrome.

3 The diagnosis is: Confirmed ☐ Who confirmed the diagnosis?

Name

Qualifications

Presumpitive ☐ Are further investigations/assessments planned to confirm the diagnosis? Yes ☐ No ☐

4 What was the date of diagnosis if known? Day Month Year

5 If the condition was acquired after birth what was the date of onset of symptoms (if known)? Day Month Year

6 Is this disability permanent? Yes ☐ No ☐

Do currently existing assessments of the person's disability or support needs verify the permanence of the person's disability or support needs? Yes ☐ No ☐

Do currently existing assessments verify the diagnoses or severity of disability? Yes ☐ No ☐

Do currently existing assessments verify or sufficiently identify support needs associated with the disability? Yes ☐ No ☐

If No for any of the above, please provide details of required assessments, including assessments that are out of date or require review:

Treatment

7 What treatment is currently being provided for this condition?

Provide specific details (e.g. date of commencement, frequency and duration of treatment or rehabilitation, type and dose of medications).

8 Does the patient wear or use any aids, equipment or assistive technology for this condition?

No ☐ **Go to next question**

Yes ☐ Give details below

9 Is any future treatment planned for this condition?

No ☐ **Go to question 11**

Yes ☐ Give details below

10 What is the expected benefit of future treatment?

Detail improvement in symptoms and functional capacity.

Functional impact

11 Details of how this condition currently impacts the patient's ability to function despite treatment, aids, equipment or assistive technology.

Describe in detail the impact on:

A Endurance.

B Movement / dexterity (e.g. walking, bending, sitting, standing, lifting / carrying / manipulating objects).

C Neurological / cognitive function (e.g. concentrating, decision making, memory, problem solving).

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D Functions of consciousness (involuntary loss of consciousness or altered consciousness e.g. seizures, migraines).

E Behaviour, planning, interpersonal relationships.

F Sensory and communication functions (e.g. seeing, hearing, speaking).

G Digestive, reproductive and continence functions.

H Need for care (e.g. support in daily living, supported accommodation or nursing home/hospital care).

I Shopping and performing household tasks.

J Driving and use of public transport.

K Other impacts as applicable.

12 Does this condition impact ability to attend and effectively participate in work, education, training or community participation?

- No ☐ **Go to next question**
- Yes ☐ Give details below

13 Within the next 2 years the impact of this condition on the patient's ability to function is expected to:

- Resolve ☐
- Significantly improve ☐
- Slightly improve ☐
- Fluctuate ☐
- Remain unchanged ☐
- Deteriorate ☐
- Uncertain ☐

Detail the functional capacity to be achieved within the next 2 years:

Other information

14 Provide any additional comments about this condition.

PART B – Vision or hearing condition

15 Does the patient have a significant vision or hearing impairment that impacts on their daily life despite appropriate intervention or aids (eg. glasses, hearing aids)?

No ☐ Remove this section of the form and go to **PART C**

Yes ☐ Give details below

Instructions for the doctor:

If the patient has more than one condition of this type, provide details here for the condition that causes the greatest impact on ability to function. Details of other conditions can be provided at PART I.

Please provide answers to the following questions based on clinical assessment, results of tests and investigations, and current scientific knowledge. Self-reported symptoms alone are not sufficient.

Attach • A report from the doctor or specialist doctor who usually treats this condition.

Diagnosis

16 What is the diagnosis?
Provide specific details:

17 The diagnosis is: Confirmed ☐ Who confirmed the diagnosis?

Name

Qualifications

Presumpitive ☐ Are further investigations/assessments planned to confirm the diagnosis? Yes ☐ No ☐

18 What was the date of diagnosis if known? Day Month Year

19 If the condition was acquired after birth what was the date of onset of symptoms (if known)? Day Month Year

20 Is this disability permanent? Yes ☐ No ☐

Do currently existing assessments of the person's disability or support needs verify the permanence of the person's disability or support needs? Yes ☐ No ☐

Do currently existing assessments verify the diagnoses or severity of disability? Yes ☐ No ☐

Do currently existing assessments verify or sufficiently identify support needs associated with the disability? Yes ☐ No ☐

If No for any of the above, please provide details of required assessments, including assessments that are out of date or require review:

21 What treatment is currently being provided for this condition?

22 How effective are current interventions? Describe the response and results of interventions.

23 What treatment has been undertaken in the past?

24 Does the patient currently wear or use any aids, equipment or assistive technology for this condition (eg. hearing aids, cochlear implants, guide or assistance dog, visual aids, etc.)?

No ☐ **Go to next question**

Yes ☐ Give details below

25 Is any future treatment planned for this condition?

No ☐ **Go to question 27**

Yes ☐ Give details below

26 What is the expected benefit of future treatment?

Detail improvement in symptoms and functional capacity.

Current symptoms

27 What symptoms currently persist despite treatment, aids, equipment or assistive technology (eg. tinnitus, nystagmus, vertigo)? Be specific and include severity, frequency and duration of symptoms.

Functional impact

28 Details of how this condition currently impacts the patient's ability to function despite treatment, aids, equipment or assistive technology:

A	Can the patient complete tasks around their home and community without difficulty?	Yes ☐	No ☐
B	Can the patient walk (or mobilise independently) to local facilities?	Yes ☐	No ☐
C	Can the patient walk (or mobilise independently) from a carpark into a shopping centre or building without assistance?	Yes ☐	No ☐
D	Can the patient walk (or mobilise independently) around a shopping centre without assistance?	Yes ☐	No ☐
E	Can the patient use public transport without assistance?	Yes ☐	No ☐
F	Is the patient capable of performing household activities (e.g. cooking, folding and putting away laundry)?	Yes ☐	No ☐
G	Does their vision or hearing impairment impact on their ability to communicate and/or participate in interpersonal interactions (including when using communication devices such as telephones)?	Yes ☐	No ☐
H	Can the patient move around inside the home without assistance?	Yes ☐	No ☐

I Describe any other impacts.

29 Does this condition impact ability to attend and effectively participate in work, education or training activities?

No ☐ **Go to next question**

Yes ☐ Give details below

30 The impact of this condition on the patient's ability to function is expected to persist for:

Less than 3 months ☐ 3-24 months ☐ More than 24 months ☐

Is the disability permanent? Yes ☐ No ☐

31 Within the next 2 years the impact of this condition on the patient's ability to function is expected to:

- Resolve ☐
- Significantly improve ☐
- Slightly improve ☐
- Fluctuate ☐
- Remain unchanged ☐
- Deteriorate ☐
- Resolve ☐
- Uncertain ☐

Detail the functional capacity to be achieved within the next 2 years:

Other information

32 Provide any additional comments about this condition.

PART C – Psychiatric and psychological conditions

PART C should be completed for mental health conditions including but not limited to: chronic depressive/anxiety disorders, schizophrenia, bipolar affective disorder, eating disorders, somatoform disorders, pathological personality disorders, post traumatic stress disorder, attention deficit hyperactivity disorder manifesting with predominantly behavioural problems, and behavioural problems related to acquired brain injury/frontal lobe syndrome.

33 Does the patient have a psychiatric or psychological condition?

No ☐ Remove this section of the form and go to **PART D**

Yes ☐ Give details below

Instructions for the doctor:

If the patient has more than one condition of this type, provide details here for the condition that causes the greatest impact on ability to function. Details of other conditions can be provided at PART I.

Please provide answers to the following questions based on clinical assessment, results of tests and investigations, and current scientific knowledge.

Self-reported symptoms alone are not sufficient.

Attach • A report from the doctor or specialist doctor who usually treats this condition (if not you).

Diagnosis

34 What is the diagnosis?
Provide specific details:

35 The diagnosis is:

Confirmed ☐ Who confirmed the diagnosis?

Name

Qualifications

Presumpitive ☐ Are further investigations/assessments planned to confirm the diagnosis?

Provide details

36 Has the diagnosis of this condition been made by a consultant psychiatrist?

No ☐ Go to next question

Yes ☐ Provide details of the treating psychiatrist

Name

Qualifications

Address

State Postcode

Phone number

Date(s) the patient has consulted the psychiatrist. If more than 4, include date of first consultation and date of most recent consultation

Day	Month	Year	Day	Month	Year
Day	Month	Year	Day	Month	Year

Attach • Attach a report from this treating psychiatrist. **This report MUST be attached.**

37 Has the diagnosis been made by the patient's treating doctor?

No ☐ Go to next question

Yes ☐

Provide details of the GP who is responsible for management of this person's mental health condition

Name

Qualifications

Address

State Postcode

Phone number

Date(s) the patient has consulted this medical practitioner. If more than 4, include date of first consultation and date of most recent consultation.

Day Month Year | Day Month Year

Day Month Year | Day Month Year

Attach • Attach a report from this treating doctor (if not you). **This report MUST be attached.**

38 Has the diagnosis been confirmed by a clinical psychologist (i.e. a psychologist with specialised qualifications which legally entitle them to diagnose and treat psychiatric and psychological conditions in their country/countries of practice)?

No ☐ Go to next question

Yes ☐ Provide details of the clinical psychologist

Name

Qualifications

Address

State Postcode

Phone number

Date(s) the patient has consulted this clinical psychologist. If more than 4, include date of first consultation and date of most recent consultation.

Day Month Year | Day Month Year

Day Month Year | Day Month Year

Attach • Attach a report from this treating doctor (if not you).

39 What was the date of diagnosis if known?

Day Month Year

40 If the condition was acquired after birth what was the date of onset of symptoms (if known)?

Day Month Year

41 What is the prognosis of this condition.

Give a timeframe, if applicable.

42 What treatment is currently being provided for this condition?

Provide specific details (e.g. date of commencement, frequency and duration of treatment or rehabilitation, type and dose of medications).

43 Is any future treatment planned for this condition?

No ☐ **Go to question 46**

Yes ☐ Give details below

44 What is the expected benefit of future treatment?

Detail improvement in symptoms and functional capacity.

45 Indicate compliance with recommended treatment:

Very compliant ☐ Usually compliant ☐ Rarely compliant ☐ Uncertain ☐

Detail any issues related to accessing or undertaking suitable treatment that affect compliance levels

Current symptoms

46 What symptoms currently persist despite treatment, aids, equipment or assistive technology?

Be specific and include severity, frequency, and duration of symptoms.

Treatment

47 Details of how this condition currently impacts the patient's ability to function despite treatment:

A Does the patient have difficulty with self care and independent living?

No ☐ **Go to B**

Yes ☐ Provide details and examples below

B Does the patient have difficulty with social/recreational activities and travel?

No ☐ **Go to C**

Yes ☐ Provide details and examples below

C Does the patient have difficulty with interpersonal relationships?

No ☐ **Go to D**

Yes ☐ Provide details and examples below

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D Does the patient have difficulty with concentration and task completion?

No ☐ **Go to E**

Yes ☐ Provide details and examples below

E Does the patient have difficulty with behaviour, planning and decision-making?

No ☐ **Go to F**

Yes ☐ Provide details and examples below

F Describe any other impacts.

48 Does this condition impact ability to attend and effectively participate in work, education, training or community participation?

No ☐ **Go to next question**

Yes ☐ Give details below

49 Within the next 2 years the impact of this condition on the patient's ability to function is expected to:

- Resolve ☐
- Significantly improve ☐
- Slightly improve ☐
- Fluctuate ☐
- Remain unchanged ☐
- Deteriorate ☐
- Uncertain ☐

Detail the functional capacity to be achieved within the next 2 years:

50 Is this condition episodic or fluctuating?

- No ☐ **Go to next question**
- Yes ☐ Describe the frequency, duration and severity of episodes, or describe how this condition fluctuates. Include a comment on work capacity during and in between episodes or fluctuating symptoms

Other information

51 Provide any additional comments about this condition.

PART D – Conditions impacting spinal function

PART D should be completed for conditions impacting spinal function including but not limited to: spinal cord injury, spinal stenosis, cervical spondylosis, lumbar radiculopathy, herniated or ruptured disc, spinal cord tumours, and arthritis or osteoporosis involving the spine.

52 Does the patient have a condition impacting spinal function?

No ☐ Remove this section of the form and go to **PART E**

Yes ☐ Does this condition result in permanent or significant impairment of daily functioning? Give details below

Instructions for the doctor:

If the patient has more than one condition of this type, provide details here for the condition that causes the greatest impact on ability to function. Details of other conditions can be provided at PART I.

Please provide answers to the following questions based on clinical assessment, results of tests and investigations, and current scientific knowledge.

Self-reported symptoms alone are not sufficient.

Attach

- A report from the doctor or specialist doctor who usually treats this condition (if not you), and
- Copies of relevant test and investigation results (e.g. x-rays or other imagery – reports only) along with reports from physiotherapists or other rehabilitation practitioners confirming loss of range of movement in the spine or other effects of the spinal disease or injury, if available.

Diagnosis

53 What is the diagnosis?
Provide specific details:

54 The diagnosis is:

Confirmed ☐ Who confirmed the diagnosis?

Name

Qualifications

Presumpitive ☐ Are further investigations/assessments planned to confirm the diagnosis? Yes ☐ No ☐

55 What was the date of diagnosis if known?

Day Month Year

56 If the condition was acquired after birth what was the date of onset of symptoms (if known)?

Day Month Year

57 Is this disability permanent? Yes ☐ No ☐

Do currently existing assessments of the person's disability or support needs verify the permanence of the person's disability or support needs? Yes ☐ No ☐

Do currently existing assessments verify the diagnoses or severity of disability? Yes ☐ No ☐

Do currently existing assessments verify or sufficiently identify support needs associated with the disability? Yes ☐ No ☐

If No for any of the above, please provide details of required assessments, including assessments that are out of date or require review:

Treatment

58 What treatment is currently being provided for this condition?

Provide specific details (e.g. date of commencement, frequency and duration of treatment or rehabilitation, type and dose of medications).

59 Describe any adverse effects of treatment, including severity.

60 What treatment has been undertaken in the past(e.g. hospitalisation, surgery, medication, physical therapy, rehabilitation, pain management)?

Provide specific details(e.g. date of commencement, frequency and duration of treatment or rehabilitation, type and dose of medications).

61 Does the patient wear or use any aids, equipment or assistive technology for this condition?

No ☐ **Go to next question**

Yes ☐ Give details below

62 Is any future treatment planned for this condition?

No ☐ **Go to question 65**

Yes ☐ Give details below

63 What is the expected benefit of future treatment?

Detail improvement in symptoms and functional capacity.

64 Indicate compliance with recommended treatment:

Very compliant ☐ Usually compliant ☐ Rarely compliant ☐ Uncertain ☐

Detail any issues related to accessing or undertaking suitable treatment that affect compliance levels

Current symptoms

65 What symptoms currently persist despite treatment, aids, equipment or assistive technology? Be specific and include severity, frequency, and duration of symptoms.

Functional impact

66 Details of how this condition currently impacts the patient's ability to function despite treatment, aids, equipment or assistive technology:

Note: Answers should reflect limitations from the spinal condition only. Answers should NOT reflect limitations from any other condition (e.g. an upper or lower limb condition).

A	Is there any restriction of forward flexion of the thoracolumbar spine?	No ☐ Go to E Yes ☐ Go to B
B	Can the patient bend to knee level and straighten up again without difficulty?	Yes ☐ No ☐
C	Can the patient bend forward to pick up a light object at knee height?	Yes ☐ No ☐
D	Can the patient bend forward to pick up a light object from a desk or table?	Yes ☐ No ☐
E	Is there any restriction of thoracolumbar spine rotation?	Yes ☐ No ☐
F	Is there any restriction of cervical spine rotation or extension?	No ☐ Go to K Yes ☐ Go to G
G	Can the patient perform any overhead activities?	Yes ☐ No ☐
H	Can the patient perform overhead activities without difficulty?	Yes ☐ No ☐
I	Does the patient have some difficulty with overhead activities?	Yes ☐ No ☐
J	Can the patient sustain overhead activities?	Yes ☐ No ☐
K	Is there restriction of some or all cervical spine movements?	No ☐ Go to P Yes ☐ Go to L
L	Does the patient have some difficulty with cervical spine movements?	Yes ☐ No ☐
M	Does the patient have difficulty with cervical spine movements in all directions?	Yes ☐ No ☐
N	Is there complete loss of cervical spine rotation?	Yes ☐ No ☐
O	Is there complete loss of cervical spine forward flexion?	Yes ☐ No ☐
P	Is the patient able to remain seated for more than 30 minutes?	No ☐ Go to Q Yes ☐ Go to R
Q	Is the patient able to remain seated for more than 10 minutes?	Yes ☐ No ☐
R	Is the patient able to get up out of a chair without assistance?	Yes ☐ No ☐

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67 Continued

S Does the patient have sufficient spinal movement to complete basic activities of daily living (e.g. dressing, bathing, showering or light housework)? Yes ☐ No ☐

T Is the patient completely unable to perform activities involving spinal function? Yes ☐ No ☐

U Describe any other impacts:

68 Does this condition impact ability to attend and effectively participate in work, education or training activities?

No ☐ **Go to next question**

Yes ☐ Give details below

69 Within the next 2 years the impact of this condition on the patient's ability to function is expected to:

- Resolve ☐
- Significantly improve ☐
- Slightly improve ☐
- Fluctuate ☐
- Remain unchanged ☐
- Deteriorate ☐
- Uncertain ☐

Detail the functional capacity to be achieved within the next 2 years:

Other information

70 Provide any additional comments about this condition.

PART E – Conditions impacting upper limb function

PART E should be completed for conditions impacting upper limb function including but not limited to: arthritis, paralysis or loss of strength or sensation resulting from stroke or other brain or nerve injury, cerebral palsy or other condition affecting upper limb coordination, inflammation or injury of the muscles or tendons, amputation and absence of whole or part of the upper limb.

71 Does the patient have a condition impacting upper limb function?

No ☐ Remove this section of the form and go to **PART F**

Yes ☐ Does this condition result in permanent or significant impairment of daily functioning? Give details below

Instructions for the doctor:

If the patient has more than one condition of this type, provide details here for the condition that causes the greatest impact on ability to function. Details of other conditions can be provided at PART I.

Please provide answers to the following questions based on clinical assessment, results of tests and investigations, and current scientific knowledge.

Self-reported symptoms alone are not sufficient.

Attach

- A report from the doctor or specialist doctor who usually treats this condition (if not you), and
- Copies of relevant test and investigation results (e.g. x-rays or other imagery – reports only), along with results of physical tests or assessments of function, if available.

Diagnosis

72 What is the diagnosis?
Provide specific details:

73 The diagnosis is:

Confirmed ☐ Who confirmed the diagnosis?

Name

Qualifications

Presumptive ☐ Are further investigations/assessments planned to confirm the diagnosis? Yes ☐ No ☐

74 What was the date of diagnosis if known?

Day Month Year

75 If the condition was acquired after birth what was the date of onset of symptoms (if known)?

Day Month Year

76 Is this disability permanent? Yes ☐ No ☐

Do currently existing assessments of the person's disability or support needs verify the permanence of the person's disability or support needs? Yes ☐ No ☐

Do currently existing assessments verify the diagnoses or severity of disability? Yes ☐ No ☐

Do currently existing assessments verify or sufficiently identify support needs associated with the disability? Yes ☐ No ☐

If No for any of the above, please provide details of required assessments, including assessments that are out of date or require review:

Treatment

77 What treatment is currently being provided for this condition?

Provide specific details (e.g. date of commencement, frequency and duration of treatment or rehabilitation, type and dose of medications).

78 Does the patient wear or use any aids, equipment or assistive technology for this condition?

No ☐ **Go to next question**

Yes ☐ Give details below

79 Is any future treatment planned for this condition?

No ☐ **Go to question 81**

Yes ☐ Give details below

80 What is the expected benefit of future treatment?

Detail improvement in symptoms and functional capacity.

Current symptoms

81 What symptoms currently persist despite treatment, aids, equipment or assistive technology?Be specific and include severity, frequency, and duration of symptoms.

82 Which limb is affected? Left ☐ Right ☐

83 Is the patient left or right dominant? Left ☐ Right ☐

Functional impact

84 Details of how this condition currently impacts the patient's ability to function despite treatment, aids, equipment or assistive technology:

A	Can the patient pick up, handle, manipulate and use most objects encountered on a daily basis without difficulty?	Yes ☐	No ☐
B	Can the patient pick up heavier objects without difficulty (e.g. a 2 litre carton of liquid or a full shopping bag)?	Yes ☐	No ☐
C	Can the patient handle very small objects without difficulty (e.g. coins)?	Yes ☐	No ☐
D	Can the patient do up buttons without difficulty?	Yes ☐	No ☐

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E	Can the patient reach up or out to pick up objects without difficulty?	Yes ☐ No ☐
F	Can the patient pick up a 1 litre carton of liquid without difficulty?	Yes ☐ No ☐
G	Can the patient pick up light objects using 2 hands together without difficulty?	Yes ☐ No ☐
H	Can the patient hold and use a pen or pencil without difficulty?	No ☐ Go to P Yes ☐ Go to L
I	The degree of difficulty to hold and use a pen or pencil is(tick one):	Mild ☐ Moderate ☐ Severe ☐
J	Can the patient use a standard keyboard without difficulty?	No ☐ Go to K Yes ☐ Go to L
K	Can the patient use a computer keyboard with appropriate adaptations without difficulty	Yes ☐ No ☐
L	Can the patient unscrew a lid on a soft-drink bottle without difficulty?	Yes ☐ No ☐
M	Does the patient have an amputation rendering a hand or arm non-functional?	Yes ☐ No ☐
N	Does the patient have limited movement or coordination in either their hands or arms severely limiting activities (Note: Both hands or both arms)?	Yes ☐ No ☐
O	Does the patient use or wear any prosthesis or assistive device?	No ☐ Go to R Yes ☐ Go to P
P	Is there any difficulty handling, moving or carrying most objects?	No ☐ Go to R Yes ☐ Go to Q
Q	The degree of difficulty handling, moving or carrying most objects (tick one):	Mild ☐ Moderate ☐ Severe ☐
R	Can the patient turn the pages of a book without difficulty and without assistance?	No ☐ Go to S Yes ☐ Go to T
S	The degree of difficulty turning the pages of a book without assistance is (tick one):	Mild ☐ Moderate ☐ Severe ☐
T	Does the patient have no capacity to use either their hands or arms (Note: Both hands or both arms)?	Yes ☐ No ☐

U Describe any other impacts:

85 Does this condition impact ability to attend and effectively participate in work, education or training activities?

No ☐ **Go to next question**

Yes ☐ Give details below

86 The impact of this condition on the patient's ability to function is expected to persist for:

Less than 3 months ☐ 3-24 months ☐ More than 24 months ☐

Is the disability permanent? Yes ☐ No ☐

87 Within the next 2 years the impact of this condition on the patient's ability to function is expected to:

Resolve ☐

Significantly improve ☐

Slightly improve ☐

Fluctuate ☐

Remain unchanged ☐

Deteriorate ☐

Uncertain ☐

Detail the functional capacity to be achieved within the next 2 years:

88 Is this condition episodic or fluctuating?

No ☐ **Go to next question**

Yes ☐ Describe the frequency, duration and severity of episodes, or describe how this condition fluctuates. Include a comment on work capacity during and in between episodes or fluctuating symptoms.

Other information

89 Provide any additional comments about this condition.

PART F – Conditions impacting lower limb function

PART F should be completed for conditions impacting lower limb function including but not limited to: arthritis, paralysis or loss of strength or sensation resulting from stroke or other brain or nerve injury, cerebral palsy or other condition affecting lower limb coordination, inflammation or injury of the muscles or tendons, amputation and absence of whole or part of the lower limb.

90 Does the patient have a condition impacting lower limb function?

No ☐ Remove this section of the form and go to **PART G**

Yes ☐ Does this condition result in permanent or significant impairment of daily functioning? Give details below

Instructions for the doctor:

If the patient has more than one condition of this type, provide details here for the condition that causes the greatest impact on ability to function. Details of other conditions can be provided at PART I.

Please provide answers to the following questions based on clinical assessment, results of tests and investigations, and current scientific knowledge.

Self-reported symptoms alone are not sufficient.

Attach

- A report from the doctor or specialist doctor who usually treats this condition (if not you), and
- Copies of relevant test and investigation results (e.g. x-rays or other imagery – reports only), along with results of physical tests or assessments of function, if available.

Diagnosis

91 What is the diagnosis?
Provide specific details:

92 The diagnosis is:

Confirmed ☐ Who confirmed the diagnosis?

Name

Qualifications

Presumptive ☐ Are further investigations/assessments planned to confirm the diagnosis? Yes ☐ No ☐

93 What was the date of diagnosis if known?

Day Month Year

94 If the condition was acquired after birth what was the date of onset of symptoms (if known)?

Day Month Year

95 Is this disability permanent? Yes ☐ No ☐

Do currently existing assessments of the person's disability or support needs verify the permanence of the person's disability or support needs? Yes ☐ No ☐

Do currently existing assessments verify the diagnoses or severity of disability? Yes ☐ No ☐

Do currently existing assessments verify or sufficiently identify support needs associated with the disability? Yes ☐ No ☐

If No for any of the above, please provide details of required assessments, including assessments that are out of date or require review:

Treatment

96 What treatment is currently being provided for this condition (e.g. hospitalisation, surgery, medication, physical therapy, rehabilitation, pain management)?

Provide specific details (e.g. date of commencement, frequency and duration of treatment or rehabilitation, type and dose of medications).

97 Does the patient wear or use any aids, equipment or assistive technology for this condition?

No ☐ **Go to next question**

Yes ☐ Give details below

98 Is any future treatment planned for this condition?

No ☐ **Go to question 100**

Yes ☐ Give details below

99 What is the expected benefit of future treatment?

Detail improvement in symptoms and functional capacity.

Current symptoms

100 What symptoms currently persist despite treatment, aids, equipment or assistive technology? Be specific and include severity, frequency, and duration of symptoms.

Functional impact

101 Details of how this condition currently impacts the patient's ability to function despite treatment, aids, equipment or assistive technology:

A	Does the patient have difficulty walking?	No ☐ Go to I Yes ☐ Go to B	
B	Can the patient walk to local facilities without difficulty?	Yes ☐	No ☐
C	Can the patient walk without difficulty around a shopping mall or supermarket without a rest?	Yes ☐	No ☐
D	How far can the patient walk outside their home?	Yes ☐	No ☐
E	Does the patient need to drive or use other transport to get to local shops and facilities?	Yes ☐	No ☐
F	Does the patient need assistance to walk around a shopping centre or supermarket?	Yes ☐	No ☐

Continued on page 27

G	Does the patient need assistance to walk from a car park into a shopping centre or supermarket?	Yes ☐ No ☐
H	Is the patient unable to mobilise independently?	Yes ☐ No ☐
I	Does the patient use a lower limb prosthesis or a walking stick?	No ☐ Go to K Yes ☐ Go to J
J	Can the patient mobilise effectively using the prosthesis or walking stick?	Yes ☐ No ☐
K	Does the patient use a wheelchair?	No ☐ Go to K Yes ☐ Go to L
L	Can the patient use the wheelchair independently?	Yes ☐ No ☐
M	Can the patient transfer to and from the wheelchair without assistance?	Yes ☐ No ☐
N	Does the patient use walking aids (e.g. quad stick, crutches or walking frame)?	No ☐ Go to Q Yes ☐ Go to O
O	Does the patient move around independently using walking aids?	Yes ☐ No ☐
P	Does the patient require assistance to move around using walking aids, (i.e. need assistance from another person to walk on some surfaces)?	Yes ☐ No ☐
Q	Can the patient stand unaided for at least 10 minutes?	No ☐ Go to R Yes ☐ Go to P
R	Can the patient stand unaided for 5-10 minutes?	Yes ☐ No ☐
S	Can the patient stand up from a sitting position without assistance?	Yes ☐ No ☐
T	Can the patient use stairs without difficulty?	No ☐ Go to U Yes ☐ Go to W
U	Can the patient stand unaided for 5-10 minutes?	Yes ☐ No ☐
V	Can the patient stand up from a sitting position without assistance?	Yes ☐ No ☐
W	Can the patient stand unaided for 5-10 minutes?	Yes ☐ No ☐
X	Can the patient use a motor vehicle?	Yes ☐ No ☐
Y	Can the patient use public transport without assistance?	Yes ☐ No ☐

Z Describe any other impacts:

102 Does this condition impact ability to attend and effectively participate in work, education or training activities?

- No → **Go to next question**
- Yes → Give details below

103 Within the next 2 years the impact of this condition on the patient's ability to function is expected to:

- Resolve
- Significantly improve → Detail the functional capacity to be achieved within the next 2 years:
- Slightly improve
- Fluctuate
- Remain unchanged
- Deteriorate
- Uncertain

Other information

104 Provide any additional comments about this condition.

PART G – Cardiovascular, respiratory and other conditions impacting physical exertion or stamina

PART G should be completed for conditions impacting physical exertion or stamina including but not limited to: cardiac failure, cardiomyopathy, ischaemic heart disease, chronic obstructive airways/pulmonary disease, asbestosis, mesothelioma, lung cancer, chronic pain which impacts physical exertion or stamina, end stage organ failure, widespread/metastatic cancer and chronic fatigue syndrome.

105 Does the patient have a cardiovascular, respiratory or other condition impacting physical exertion or stamina?

No ☐ Remove this section of the form and go to **PART H**

Yes ☐ Give details below

Instructions for the doctor:

If the patient has more than one condition of this type, provide details here for the condition that causes the greatest impact on ability to function. Details of other conditions can be provided at PART I.

Please provide answers to the following questions based on clinical assessment, results of tests and investigations, and current scientific knowledge. Self-reported symptoms alone are not sufficient.

Attach

- A report from the doctor or specialist doctor who usually treats this condition (if not you), and
- Copies of relevant test and investigation results (e.g. lung function tests, blood tests, exercise tolerance tests, ECG – reports only), if available.

Diagnosis

106 What is the diagnosis?
Provide specific details:

107 The diagnosis is:

Confirmed ☐ Who confirmed the diagnosis?

Name

Qualifications

Presumptive ☐ Are further investigations/assessments planned to confirm the diagnosis? Yes ☐ No ☐

108 What was the date of diagnosis if known?

Day Month Year

109 If the condition was acquired after birth what was the date of onset of symptoms (if known)?

Day Month Year

110 Is this disability permanent? Yes ☐ No ☐

Do currently existing assessments of the person's disability or support needs verify the permanence of the person's disability or support needs? Yes ☐ No ☐

Do currently existing assessments verify the diagnoses or severity of disability? Yes ☐ No ☐

Do currently existing assessments verify or sufficiently identify support needs associated with the disability? Yes ☐ No ☐

If No for any of the above, please provide details of required assessments, including assessments that are out of date or require review:

Treatment

111 What treatment is currently being provided for this condition?

Provide specific details (e.g. date of commencement, frequency and duration of treatment or rehabilitation, type and dose of medications).

112 How effective is current treatment?

Describe response to treatment and degree of control of symptoms.

113 Describe any adverse effects of treatment, including severity.

114 What treatment has been undertaken in the past(e.g. hospitalisation, surgery, medication, physical therapy, rehabilitation, pain management)?

Provide specific details(e.g. date of commencement, frequency and duration of treatment or rehabilitation, type and dose of medications).

115 Does the patient wear or use any aids, equipment or assistive technology for this condition?

No ☐ **Go to next question**

Yes ☐ Give details below

116 Is any future treatment planned for this condition?

No ☐ **Go to question 117**

Yes ☐ Give details below

117 What is the expected benefit of future treatment?

Detail improvement in symptoms and functional capacity.

Functional impact

118 Details of how this condition currently impacts the patient's ability to function despite treatment, aids, equipment or assistive technology:

A	Can the patient complete physically active tasks around their home and community without difficulty?	Yes ☐	No ☐
B	Can the patient complete physically active tasks around their home and community without difficulty?	Yes ☐	No ☐
C	Can the patient walk (or mobilise independently in a wheelchair) to local facilities without stopping to rest?	Yes ☐	No ☐
D	Can the patient walk (or mobilise independently in a wheelchair) from a carpark into a shopping centre or building without assistance?	Yes ☐	No ☐
E	Can the patient walk (or mobilise independently in a wheelchair) around a shopping centre without assistance?	Yes ☐	No ☐
F	Can the patient climb a flight of stairs or mobilise in a wheelchair up a long, sloping ramp?	Yes ☐	No ☐
G	Can the patient use public transport without assistance?	Yes ☐	No ☐
H	Is the patient physically capable of performing light household activities (e.g. folding and putting away laundry)?	Yes ☐	No ☐
I	Can the patient perform day to day household activities without difficulty (e.g. changing sheets on a bed or sweeping paths)?	Yes ☐	No ☐
J	Can the patient move around inside the home without assistance?	Yes ☐	No ☐
K	Does the patient require oxygen treatment during the day or to move around?	Yes ☐	No ☐

L Describe any other impacts.

119 Does this condition impact ability to attend and effectively participate in work, education, training or community participation?

No ☐ **Go to next question**

Yes ☐ Give details below

120 The impact of this condition on the patient's ability to function is expected to persist for:

Less than 6 months ☐ 6-12 months ☐ More than 12 months ☐

121 Within the next 2 years the impact of this condition on the patient's ability to function is expected to:

- Resolve ☐
- Significantly improve ☐
- Slightly improve ☐
- Fluctuate ☐
- Remain unchanged ☐
- Deteriorate ☐
- Uncertain ☐

Detail the functional capacity to be achieved within the next 2 years:

Other information

122 Provide any additional comments about this condition.

PART H – Capacity for work or training

Instructions for the doctor:

PART H is to provide a holistic summary of the patient's current and potential capacity for work.

- Only those medical conditions with impact on functional capacity expected to persist for more than 2 years should be considered in assessing the patient's work capacity.
- Rate how the patient's work capacity is affected by their medical conditions now and over the next 2 years. This means any work the patient is capable of performing regardless of the availability of that work and without regard to the patient's age, educational level and current work skills.
- Tick one option for each column in the work capacity tables.
- Respond even if the patient has not worked for some time.

123 Indicate your assessment of the patient's capacity to do any work WITHOUT ANY INTERVENTION programs: i.e. WITHOUT programs that are designed to assist people back into the workforce (e.g. on the job training, vocational rehabilitation).

Work Capacity

	Current	Within 6 months	6-24 months	More than 24 months
0-7 hrs per week				
8-14 hrs per week				
15-29 hrs per week				
30+ hrs per week				

Type of work

Suggested suitable work

Provide reasons for work capacity and type of work recommendations

---

124 Indicate your assessment of the patient's capacity to do any work WITH INTERVENTION programs: i.e. WITH programs that are specifically designed for people with physical, intellectual or psychiatric impairments (e.g. vocational rehabilitation, disability employment services) AND those that are not (e.g. vocational or pre-vocational training, on the job training and educational programs).

Work Capacity

	Current	Within 6 months	6-24 months	More than 24 months
0-7 hrs per week				
8-14 hrs per week				
15-29 hrs per week				
30+ hrs per week				

Type of work

Suggested suitable work

Provide reasons for work capacity and type of work recommendations

125 What type(s) of assistance would best assist the patient to return to work?

- No assistance required ☐ **Go to question 126**
- Educational training (e.g. Year 12) ☐
- Vocational/work training and rehabilitation ☐
- On-the-job training ☐
- Voluntary work ☐
- Drug and alcohol assistance ☐

Go to next question

- Other ☐ Give details below

126 Indicate your assessment of the patient's interest in pursuing assistance to return to work:

Nil ☐ Minimal ☐ Moderate ☐ Substantial ☐

Give details below

PART I – Other Medical

127 Does the patient have any other medical conditions which are generally well managed and cause minimal or limited impact on ability to function?

No ☐ **You have completed this form**

Yes ☐ Give details below

Condition (diagnosis)	Treatment	Significant improvement expected?	Impact on ability to function
1		No ☐ Yes ☐	
2		No ☐ Yes ☐	
3		No ☐ Yes ☐	
4		No ☐ Yes ☐	

If there are more than 4 medical conditions which do NOT have a significant impact on ability to function, attach a separate sheet with details.

128 Patient's details:

Height

Weight

Blood Pressure

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

No ☐ **Go to next question 130**

Yes ☐ Diagnosis of condition

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

No ☐

Yes ☐

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