

**Patient's details**

Name

Address

Country	Postcode

Date of birth  
(DD MM YYYY)

--	--	--

Centrelink Customer  
Reference Number (CRN)

--	--	--	--

**PART A – Instructions for the patient**

This report will assist in determining if you are eligible for a disability/invalidity pension from a country other than Australia.

**What you should do**

You should take this report to your treating doctor.

Let your doctor or medical specialist and their receptionist know at the time of making the appointment that you will need this report completed, as a long consultation may be required. If your doctor or medical specialist does not bulk bill, your consultation fee may be more than usual because of the extra time taken to complete the report.

You will need to get the completed form from your doctor and return it to Services Australia unless your doctor returns it for you.

**Privacy and your personal  
information**

The privacy and security of your personal information is important to us, and is protected by law. We collect this information so we can process and manage your applications and payments, and provide services to you. We only share your information with other parties where you have agreed, or where the law allows or requires it. For more information, go to [servicesaustralia.gov.au/privacypolicy](https://servicesaustralia.gov.au/privacypolicy)

**Authority to release  
information****I consent to:**

- the release by Services Australia of relevant information in this report to service providers to whom I may be referred by Services Australia.
- any decision of Services Australia to refer me for any further required assessment, upon the recommendation of the medical assessor.
- the release by Services Australia of any medical evidence obtained to the relevant authority to determine my qualification for a disability/invalidity pension from a country other than Australia

**Patient's signature**

Date (DD MM YYYY)

--	--	--



CLK0AUS224 2506

## PART B – Instructions for the doctor

### About this report

This report will be used to assist in determining if your patient is medically eligible for a disability/invalidity pension from a country other than Australia.

### Payment for your report

We have asked your patient to let you know at the time of making their appointment that they require you to complete this form. This is to make sure you have sufficient time for the examination. Your patient has been informed that they are responsible for any costs in obtaining this report.

### Completing this report

In this report you will be asked to provide clinical details of the patient's medical conditions. Complete all the required parts of the form. Your patient's impairment is to be assessed when they are using or wearing any aids, equipment or assistive technology that they have and usually use (for example, hearing aids, spectacles, contact lenses or prostheses).

### Returning the report to us

Return this report and any attachments as soon as possible directly to us, or if you prefer, you can give the report and any attachments to your patient to return to us.

### About the information that you give us

#### Confidentiality of Information

The personal information that is provided to you for the purpose of this report must be kept confidential under section 202 of the *Social Security (Administration) Act 1999*. It cannot be disclosed to anyone else unless authorised by law. There are penalties for offences against section 202 of the *Social Security (Administration) Act 1999*.

#### Release of information

The *Freedom of Information Act 1982* allows for the disclosure of medical or psychiatric information directly to the individual concerned. If there is any information which, if released to your patient, may harm their physical or mental well-being, you can identify it at **PART I**. Similarly, please specify any other special circumstances which should be taken into account.

#### Privacy and your personal information

The privacy and security of your personal information is important to us, and is protected by law. We collect this information to provide payments and services. We only share your information with other parties where you have agreed, or where the law allows or requires it.

For more information, go to [servicesaustralia.gov.au/privacypolicy](https://servicesaustralia.gov.au/privacypolicy)

**Thank you for your assistance.**

## PART C – Patient details

### Filling in this form

You can complete this form on your computer using Adobe Acrobat Reader. If you do not have Adobe Acrobat Reader, you can print this form.

If you have printed the form:

- Use black or blue pen.
- Print in BLOCK LETTERS.
- Where you see a box like this  ► **Go to 1** skip to the question number shown.

### Medical information

**1** This person has been:

my patient since (DD MM YYYY)

<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------

a patient at this practice since (DD MM YYYY)

<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------

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

No ☐ ► **Go to 4**

Yes ☐ ► Give details below

Diagnosis

--------------

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

No ☐

Yes ☐

**4** Does the patient have one of more medical conditions which is unlikely to improve or stabilise within 2 years and that has a significant impact on their ability to function?

For example, endurance, walking, sitting, standing, performing daily activities, handling and manipulating objects, bending, self-care, concentration, attention, communication, hearing, vision, continence, consciousness.

No ☐

Yes ☐

**5** Give details about the conditions that have a **significant impact** on the patient's ability to function.

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

► **Go to the next page to give details for Condition 1**

## PART D – Medical conditions

### Condition 1 – condition with most impact on patient's ability to function

#### A Diagnosis


Date of onset (if known, DD MM YYYY)

--	--	--	--	--	--

The diagnosis is:

Presumptive ☐ Are further investigations or tests planned to confirm the diagnosis?

No ☐

Yes ☐

Confirmed ☐ Is the diagnosis supported by **further** specialist opinion?

No ☐

Yes ☐ Give details below

Psychiatrist or  
Psychologist

☐ Name

--

Audiologist or Ear,  
Nose and Throat  
Specialist

☐ Name

--

Ophthalmologist

☐ Name

--

Other

☐ Name and specialty


Provide relevant specialist and allied health reports.

Date of diagnosis  
(DD MM YYYY)

--	--	--	--	--	--

#### Treatment

#### B Current treatment

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

Treatment

Date of onset (DD MM YYYY)



Condition 1 – continued

Treatment – continued

C Past treatment

Provide details of past treatment for this condition (for example, hospitalisation, surgery, medication and dosage, counselling, physical therapy, rehabilitation, frequency of treatment).

Treatment	Date of onset (DD MM YYYY)			Duration of treatment

D Specialist consultation

Have you or another doctor from your practice previously referred this patient to a specialist?

No ☐  
Yes ☐ Give details below

Name	Specialty	Date of consultation (DD MM YYYY)		

E Future or planned treatment

Provide details of any further scheduled or proposed treatment with estimates of likely dates of commencement and expected duration.

Clinical features

F Current symptoms

Describe current symptoms. Be specific and include severity, frequency and duration.  
Symptoms are those persisting **despite** treatment, aids, equipment or assistive technology.

## Condition 2 – condition with with significant impact on patient's ability to function

### A Diagnosis


Date of onset (if known, DD MM YYYY)

--	--	--	--	--

The diagnosis is:

Presumptive ☐ Are further investigations or tests planned to confirm the diagnosis?

No ☐

Yes ☐

Confirmed ☐ Is the diagnosis supported by **further** specialist opinion?

No ☐

Yes ☐ Give details below

Psychiatrist or  
Psychologist

☐ Name

--

Audiologist or Ear,  
Nose and Throat  
Specialist

☐ Name

--

Ophthalmologist

☐ Name

--

Other

☐ Name and specialty


Provide relevant specialist and allied health reports.

Date of diagnosis  
(DD MM YYYY)

--	--	--	--	--

### Treatment

#### B Current treatment

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

Treatment

Date of onset (DD MM YYYY)



Condition 2 – continued

Treatment – continued

C Past treatment

Provide details of past treatment for this condition (for example, hospitalisation, surgery, medication and dosage, counselling, physical therapy, rehabilitation, frequency of treatment).

Treatment	Date of onset (DD MM YYYY)			Duration of treatment

D Specialist consultation

Have you or another doctor from your practice previously referred this patient to a specialist?

No ☐  
Yes ☐ Give details below

Name	Specialty	Date of consultation (DD MM YYYY)		

E Future or planned treatment

Provide details of any further scheduled or proposed treatment with estimates of likely dates of commencement and expected duration.

Clinical features

F Current symptoms

Describe current symptoms. Be specific and include severity, frequency and duration.  
Symptoms are those persisting **despite** treatment, aids, equipment or assistive technology.

If there are more than 2 conditions that have a **significant impact** on ability to function, provide a separate sheet with details.

### Other conditions and past medical history

**6** Provide details of any other conditions – use the questions for Conditions 1 and 2 as a guide.

[illegible]

If you need more space, provide a separate sheet with details.

## Imaging and specialist medical practitioner reports

**7** Provide relevant investigations associated with patient's conditions, including any pertinent imaging reports or laboratory test results.

[illegible]

If you need more space, provide a separate sheet with details.



## PART E – Social and employment history

### Provide details of patient's social and employment history

8 Does the patient live with anyone?

No ☐ ► *Go to next question*

Yes ☐ ► Patient's living arrangements, for example, lives with partner, carer or children.

9 Does anyone provide care for this patient?

No ☐ ► *Go to next question*

Yes ☐ ► Number of hours

 per week

10 Additional information


If you need more space, provide a separate sheet with details.

11 Is the patient gainfully employed?

No ☐ ► *Go to next question*

Yes ☐ ► Number of hours worked

 per week

► **Go to 13**

12 Details of patient not working

Stopped work ☐ on (DD MM YYYY) or approximate date

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------	----------------------	----------------------	----------------------

Reason employment has stopped


13 Type or nature of actual or last employment


## PART F – Examination

### 14 Objective examination – complete where relevant or as appropriate

#### A General condition

#### B Height

 cm

#### C Weight

 kg

#### D Cardiovascular system

#### E Pulse

#### F Respiration

#### G Blood pressure

#### H Respiratory system


#### I Spine

#### J Upper limbs

#### K Lower limbs

#### L Neurological findings


#### M Eyes and vision


**N** Ears and hearing


**O** Mental status, mood


**P** Other significant observations


## PART G – Impact on general ability to function

Please comment on conditions that are unlikely to improve or stabilise within 2 years – complete where relevant or as appropriate

**15** Describe in detail the impact on:

**A Endurance**


**B Movement or dexterity** (for example, walking, bending, sitting, standing, lifting, carrying or manipulating objects)


**C Neurological or cognitive function** (for example, concentrating, decision making, memory, problem solving)


**D Functions of consciousness** (involuntary loss of consciousness or altered consciousness, for example, seizures, migraines)


**E Behaviour, planning, interpersonal relationships**


**F Sensory and communication functions** (for example, seeing, hearing, speaking)


**G Digestive and continence functions**


**H Need for care** (for example, support in daily living, supported accommodation or nursing home or hospital care)


**I Shopping and performing household tasks**


**J Driving and use of public transport**


**K Other impacts as applicable**


## PART H – Capacity for work, education or training

Details about how patient's conditions and their treatments impact the patient's ability to participate in the labour market or workforce

### 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.
- Respond even if the patient has not worked for some time.

**16** Do these conditions impact ability to attend and effectively participate in work, education or training activities?

No ☐ ► **Go to PART I**

Yes ☐ ► **Go to next question**

**17** Can the patient work full time in their last occupation?

No ☐ ► **Go to next question**

Yes ☐ ► **Go to PART I**

**18** Work capacity

Tick one only

0–7 hrs per week ☐

8–14 hrs per week ☐

15–29 hrs per week ☐

30+ hrs per week ☐

**19** Would there be any likely or potential improvement in the patient's work capacity through medical treatment or vocational training?

No ☐ ► **Go to PART I**

Yes ☐ ► Give details below


## PART I – Privacy, confidentiality and release of medical information

## 20 Release of medical information

The *Freedom of Information Act 1982* allows for the disclosure of medical or psychiatric information directly to the individual concerned. If there is any information in your report which, if released to your patient, may harm their physical or mental well-being, identify it and briefly state below why you believe it should not be released directly to the patient. Similarly, specify any other special circumstances which should be taken into account when deciding on the release of your report.

Is there any information in this report which, if released to the patient, might be prejudicial to their physical or mental health?

No  *Go to next question*

Yes ☐ Identify the information and state why it should not be released directly to the patient.

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There is no text or other markings on the paper.

Once completed, return this report directly to:

SERVICES AUSTRALIA, CENTRELINK INTERNATIONAL SERVICES, PO BOX 7809, CANBERRA BC ACT 2610.

**21** Would you like to discuss any aspects of this report with us?

No ☐Yes ☐

**22** If someone from Services Australia, or another assessor nominated by us, needs to contact you to discuss any aspects of this report, what days and times suit you?

Day

\_\_\_\_\_

Time

□

am

pm

to

□

am

pm

Day

\_\_\_\_\_

Time

□

am

pm

to

•

am

pm

## 23 Confidentiality of Information

The personal information that is provided to you for the purpose of this report must be kept confidential under section 202 of the *Social Security (Administration) Act 1999*. It cannot be disclosed to anyone else unless authorised by law. There are penalties for offences against section 202 of the *Social Security (Administration) Act 1999*.

## Privacy notice

### 24 Important information for the doctor or medical specialist

#### You need to read this

##### Privacy and your personal information

The privacy and security of your personal information is important to us, and is protected by law. We collect this information to provide payments and services. We only share your information with other parties where you have agreed, or where the law allows or requires it. For more information, go to [servicesaustralia.gov.au/privacypolicy](https://servicesaustralia.gov.au/privacypolicy)

## PART J – Details of medical practitioner and returning the report

### 25 Print in BLOCK LETTERS or use a stamp.

Name

Professional qualifications

Address

Country	Postcode

Contact phone number

Country (    )	Area code (    )
----------------	------------------

Signature


---

Date (DD MM YYYY)

DD	MM	YYYY
----	----	------

Stamp  
(if applicable)

--

### Returning this report

You can give this report and any supporting documents to your patient or you can return this report directly to us.

However, if you answered 'Yes' at question 20, make sure to return this report directly to:

**SERVICES AUSTRALIA**  
**CENTRELINK INTERNATIONAL SERVICES**  
**PO BOX 7809**  
**CANBERRA BC ACT 2610**