Instructions Print Clear

Australian Government
Services Australia

centrelink

Treating doctor's report
Outside Australia

TDR

Patient's details

Name

Address

Country Postcode

Date of birth Day / Month / Year

Customer Centrelink Reference Number

Instructions for the patient

This report will be used to assist in determining if you are medically eligible for an Australian Disability Support Pension. Only use this form for medical assessments if you are outside of Australia.

What you should do

You should take this report to your treating doctor. Please let your doctor know at the time of making the appointment that you require this report to be completed to assess your eligibility for an Australian Disability Support Pension. You are responsible for any costs in obtaining this report.

You have to get this report back from your doctor and return it to Work and Income in New Zealand 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 need to 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/privacy**

Authority to release information

- I authorise Services Australia and/or Work and Income to obtain any medical information necessary to decide my qualification for pension – from my doctor(s), other health professionals and public or private health facilities I have visited.
- I authorise Services Australia and/or Work and Income to obtain any information necessary to decide my qualification for pension from any public or private education facilities I have attended or am currently attending.
- I consent to the release by Services Australia and/or Work and Income of relevant information in this report to service providers to whom I may be referred by Services Australia and/or Work and Income.
- I consent to any decision of Services Australia to refer me for any further required assessment, upon the recommendation of the medical assessor.

Patient's signature

On completion of this form, print and sign by hand

Date Day / Month / Year

CLK0AUS109NZ 2011

About this report

This report will be used to assist in determining if your patient is medically eligible for an Australian Disability Support Pension.

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 ensure 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. Please 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 (e.g. hearing aids, spectacles, contact lenses or prostheses).

Returning the report to us

Please return this report and any attachments as soon as possible directly to Work and Income in New Zealand, or if you prefer, you can give the report, and any attachments to your patient to return to Work and Income in New Zealand. This information is needed to help determine your patient's claim for Australian social security assistance.

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

Is there any information in this report which, if released to your patient, might be prejudicial to his/her physical or mental health?

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 his or her physical or mental well-being, please identify it and briefly state below why you believe it should not be released directly to your patient. Similarly, please specify any other special circumstances which should be taken into account when deciding on the release of your report.

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/privacy**

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

PART A 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.

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

No ☐ ***Go to PART B***

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 F.

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

2 What is the diagnosis?
Provide specific details (e.g. include the International Classification of Diseases code and/or staging as relevant).

3 The diagnosis is:

Confirmed ☐ Who confirmed the diagnosis?

Name

Qualifications

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

4 What was the date of diagnosis?

Day / Month / Year

5 What was the date of onset of symptoms (if known)?

Day / Month / Year

6 What is the prognosis of this condition?
Give a timeframe, if applicable.

Treatment

7 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).

8 How effective is current treatment?
Describe response to treatment and degree of control of symptoms.

9 Describe any adverse effects of treatment, including severity.

10 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).

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

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

12 Is any future treatment planned for this condition?

No ☐ ***Go to 14***
Yes ☐ Give details below

13 What is the expected benefit of future treatment?
Detail improvement in symptoms *and* functional capacity.

14 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

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

Functional impact

16 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? No ☐ Yes ☐

B Can the patient walk (or mobilise independently in a wheelchair) to local facilities? No ☐ Yes ☐

C Can the patient walk (or mobilise independently in a wheelchair) to local facilities without stopping to rest? No ☐ Yes ☐

D Can the patient walk (or mobilise independently in a wheelchair) from a carpark into a shopping centre or building without assistance? No ☐ Yes ☐

E Can the patient walk (or mobilise independently in a wheelchair) around a shopping centre without assistance? No ☐ Yes ☐

F Can the patient climb a flight of stairs or mobilise in a wheelchair up a long, sloping ramp? No ☐ Yes ☐

G Can the patient use public transport without assistance? No ☐ Yes ☐

H Is the patient physically capable of performing light household activities (e.g. folding and putting away laundry)? No ☐ Yes ☐

I Can the patient perform day to day household activities without difficulty (e.g. changing sheets on a bed or sweeping paths)? No ☐ Yes ☐

J Can the patient move around inside the home without assistance? No ☐ Yes ☐

K Does the patient require oxygen treatment during the day or to move around? No ☐ Yes ☐

L Describe any other impacts.

17 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

18 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 ☐

19 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.

20 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

21 History of this condition.
Provide details of underlying causes and contributing factors.

22 Provide any additional comments about this condition.

PART B – Conditions impacting spinal function

PART B 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.

23 Does the patient have a condition impacting spinal function?

No ☐ ▶ ***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 F.

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

24 What is the diagnosis?
Provide specific details (e.g. include the International Classification of Diseases code and/or staging as relevant).

25 The diagnosis is:

Confirmed ☐ ▶ Who confirmed the diagnosis?

Name

Qualifications

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

26 What was the date of diagnosis?

Day / Month / Year

27 What was the date of onset of symptoms (if known)?

Day / Month / Year

28 What is the prognosis of this condition?
Give a timeframe, if applicable.

Treatment

29 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).

30 How effective is current treatment?
Describe response to treatment and degree of control of symptoms.

31 Describe any adverse effects of treatment, including severity.

32 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).

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

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

34 Is any future treatment planned for this condition?

No ☐ ▶ ***Go to 36***
Yes ☐ ▶ Give details below

35 What is the expected benefit of future treatment?
Detail improvement in symptoms *and* functional capacity.

36 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

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

Functional impact

38 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?	No ☐	Yes ☐
C	Can the patient bend forward to pick up a light object at knee height?	No ☐	Yes ☐
D	Can the patient bend forward to pick up a light object from a desk or table?	No ☐	Yes ☐
E	Is there any restriction of thoracolumbar spine rotation?	No ☐	Yes ☐
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?	No ☐	Yes ☐
H	Can the patient perform overhead activities without difficulty?	No ☐	Yes ☐
I	Does the patient have some difficulty with overhead activities?	No ☐	Yes ☐
J	Can the patient sustain overhead activities?	No ☐	Yes ☐
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?	No ☐	Yes ☐
M	Does the patient have difficulty with cervical spine movements in all directions?	No ☐	Yes ☐
N	Is there complete loss of cervical spine rotation?	No ☐	Yes ☐
O	Is there complete loss of cervical spine forward flexion?	No ☐	Yes ☐
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?	No ☐	Yes ☐
R	Is the patient able to get up out of a chair without assistance?	No ☐	Yes ☐
S	Does the patient have sufficient spinal movement to complete basic activities of daily living (e.g. dressing, bathing, showering or light housework)?	No ☐	Yes ☐
T	Is the patient completely unable to perform activities involving spinal function?	No ☐	Yes ☐

U Describe any other impacts.

39 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

40 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 ☐

41 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.

42 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

43 History of this condition.

Provide details of underlying causes and contributing factors.

44 Provide any additional comments about this condition.

PART C – Conditions impacting upper limb function

PART C 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.

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

No ☐ ***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 F.

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

46 What is the diagnosis?
Provide specific details (e.g. include the International Classification of Diseases code and/or staging as relevant).

47 The diagnosis is:

Confirmed ☐ Who confirmed the diagnosis?

Name

Qualifications

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

48 What was the date of diagnosis?

Day / Month / Year

49 What was the date of onset of symptoms (if known)?

Day / Month / Year

50 What is the prognosis of this condition?
Give a timeframe, if applicable.

Treatment

51 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).

52 How effective is current treatment?
Describe response to treatment and degree of control of symptoms.

53 Describe any adverse effects of treatment, including severity.

54 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).

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

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

56 Is any future treatment planned for this condition?

No ☐ ▶ ***Go to 58***
Yes ☐ ▶ Give details below

57 What is the expected benefit of future treatment?
Detail improvement in symptoms *and* functional capacity.

58 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

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

60 Which limb is affected? Left ☐ Right ☐

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

Functional impact

62 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? No ☐ Yes ☐

B Can the patient pick up heavier objects without difficulty (e.g. a 2 litre carton of liquid or a full shopping bag)? No ☐ Yes ☐

C Can the patient handle very small objects without difficulty (e.g. coins)? No ☐ Yes ☐

D Can the patient do up buttons without difficulty? No ☐ Yes ☐

E Can the patient reach up or out to pick up objects without difficulty? No ☐ Yes ☐

F Can the patient pick up a 1 litre carton of liquid without difficulty? No ☐ Yes ☐

G Can the patient pick up light objects using 2 hands together without difficulty? No ☐ Yes ☐

H Can the patient hold and use a pen or pencil without difficulty? No ☐ ***Go to I*** Yes ☐ ***Go to J***

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? No ☐ Yes ☐

L Can the patient unscrew a lid on a soft-drink bottle without difficulty? No ☐ Yes ☐

M Does the patient have an amputation rendering a hand or arm non-functional? No ☐ Yes ☐

N Does the patient have limited movement or coordination in either their hands or arms severely limiting activities (**Note:** Both hands or both arms)? No ☐ Yes ☐

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 is (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)? No ☐ Yes ☐

Continued

U Describe any other impacts.

63 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

64 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 ☐

65 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.

66 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

67 History of this condition.
Provide details of underlying causes and contributing factors.

68 Provide any additional comments about this condition.

PART D – Conditions impacting lower limb function

PART D 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.

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

No ☐ ▶ ***Go to PART E***

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 F.

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

70 What is the diagnosis?
Provide specific details (e.g. include the International Classification of Diseases code and/or staging as relevant).

71 The diagnosis is:

Confirmed ☐ ▶ Who confirmed the diagnosis?

Name

Qualifications

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

72 What was the date of diagnosis?

Day / Month / Year

73 What was the date of onset of symptoms (if known)?

Day / Month / Year

74 What is the prognosis of this condition?
Give a timeframe, if applicable.

Treatment

75 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).

76 How effective is current treatment?
Describe response to treatment and degree of control of symptoms.

77 Describe any adverse effects of treatment, including severity.

78 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).

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

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

80 Is any future treatment planned for this condition?

No ☐ ▶ ***Go to 82***
Yes ☐ ▶ Give details below

81 What is the expected benefit of future treatment?
Detail improvement in symptoms *and* functional capacity.

82 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

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

Functional impact

84 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?	No ☐ Yes ☐
C	Can the patient walk without difficulty around a shopping mall or supermarket without a rest?	No ☐ Yes ☐
D	How far can the patient walk outside their home?	
E	Does the patient need to drive or use other transport to get to local shops and facilities?	No ☐ Yes ☐
F	Does the patient need assistance to walk around a shopping centre or supermarket?	No ☐ Yes ☐
G	Does the patient need assistance to walk from a car park into a shopping centre or supermarket?	No ☐ Yes ☐
H	Is the patient unable to mobilise independently?	No ☐ Yes ☐
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?	No ☐ Yes ☐
K	Does the patient use a wheelchair?	No ☐ ***Go to N*** Yes ☐ ***Go to L***
L	Can the patient use the wheelchair independently?	No ☐ Yes ☐
M	Can the patient transfer to and from the wheelchair without assistance?	No ☐ Yes ☐
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?	No ☐ Yes ☐
P	Does the patient require assistance to move around using walking aids, (i.e. need assistance from another person to walk on some surfaces)?	No ☐ Yes ☐
Q	Can the patient stand unaided for at least 10 minutes?	No ☐ ***Go to R*** Yes ☐ ***Go to S***
R	Can the patient stand unaided for 5-10 minutes?	No ☐ Yes ☐
S	Can the patient stand up from a sitting position without assistance?	No ☐ Yes ☐
T	Can the patient use stairs without difficulty?	No ☐ ***Go to U*** Yes ☐ ***Go to W***
U	Does the patient have some difficulty climbing stairs?	No ☐ Yes ☐
V	Is the patient unable to use stairs or steps without assistance?	No ☐ Yes ☐
W	Can the patient kneel or squat and rise back up to a standing position without difficulty?	No ☐ Yes ☐

Continued

X Can the patient use a motor vehicle? No ☐ Yes ☐

Y Can the patient use public transport without assistance? No ☐ Yes ☐

Z Describe any other impacts.

84 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 ☐

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 History of this condition.

Provide details of underlying causes and contributing factors.

90 Provide any additional comments about this condition.

PART E – Psychiatric and psychological conditions

PART E 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.

91 Does the patient have a psychiatric or psychological condition?

No ☐ ▶ ***Go to PART F***

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 F.

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

92 What is the diagnosis? Provide specific details (e.g. include the International Classification of Diseases code or the Diagnostic and Statistical Manual of Mental Disorders code).

93 The diagnosis is:

Confirmed ☐ ▶ *Go to next question*

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

No ☐ ▶ *Go to next question*

Yes ☐ ▶ Give details below

94 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

Country Postcode

Phone number Country ( ) Area code ( )

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 a report from this treating psychiatrist. This report MUST be attached.

▶ ***Go to 97***

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

No ☐ *Go to next question*

Yes ☐ Provide details of the treating doctor

Name

Qualifications

Address

Country Postcode

Phone number Country ( ) Area code ( )

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

Go to next question

96 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

Country Postcode

Phone number Country ( ) Area code ( )

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 a report from this clinical psychologist. This report MUST be attached.

97 What was the date of diagnosis?

Day Month Year / /

98 What was the date of onset of symptoms (if known)?

Day Month Year / /

99 What is the prognosis of this condition?
Give a timeframe, if applicable.

100 What treatment is currently being provided for this condition (e.g. hospitalisation, medication, counselling, cognitive behavioural therapy, rehabilitation)?
Provide specific details (e.g. date of commencement, frequency and duration of treatment or rehabilitation, type and dose of medications).

101 How effective is current treatment?
Describe response to treatment and degree of control of symptoms.

102 Describe any adverse effects of treatment, including severity.

103 What treatment has been undertaken in the past (e.g. medication, counselling, cognitive behavioural therapy, rehabilitation)?
Provide specific details (e.g. date of commencement, frequency and duration of treatment or rehabilitation, type and dose of medications).

104 Has the patient been hospitalised for this condition?

No ☐ ▶ *Go to next question*

Yes ☐ ▶ Give details below, beginning with the most recent

1

Condition (diagnosis)

Date of admission — Day / Month / Year

Duration

Reason

Name of institution

2

Condition (diagnosis)

Date of admission — Day / Month / Year

Duration

Reason

Name of institution

Continued

3

Condition (diagnosis)

Date of admission — Day / Month / Year

Duration

Reason

Name of institution

If the patient has been hospitalised more than 3 times, attach a separate sheet with details.

105 Is any future treatment planned for this condition?

No ☐ ▶ ***Go to 107***

Yes ☐ ▶ Give details below

106 What is the expected benefit of future treatment?
Detail improvement in symptoms *and* functional capacity.

107 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

108 What symptoms currently persist **despite** treatment?
Be specific and include severity, frequency, and duration of symptoms.

109 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

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 E***

Yes ☐ Provide details and examples below

F Describe any other impacts.

110 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

111 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 ☐

112 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 ☐

113 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

114 History of this condition.

Provide details of underlying causes and contributing factors.

115 Provide any additional comments about this condition.

PART F – Other medical conditions

116 Does the patient have any other medical conditions including intellectual impairment 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 ☐ ***Go to PART G***

Yes ☐ Give details below

Instructions for the doctor

Detail only one condition at a time – avoid grouping medical conditions. **If there is more than 1 other condition, photocopy pages 25–28 for each additional condition, answer the questions and attach the completed pages to this form.**

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:
- *if this condition impacts vision* **a report from an Ophthalmologist. This report MUST be attached**,
- *if this condition impacts hearing or other ear functions* **a report from an Audiologist or Ear, Nose and Throat specialis. This report MUST be attached**,
- a report from the doctor or specialist doctor who usually treats this condition (if not you), and
- results of relevant test and investigation results (reports only), if available.

Diagnosis

117 What is the diagnosis?
Provide specific details (e.g. include the International Classification of Diseases code and/or staging as relevant).

118 The diagnosis is:

Confirmed ☐ Who confirmed the diagnosis?

Name

Qualifications

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

119 What was the date of diagnosis?

Day / Month / Year

120 What was the date of onset of symptoms (if known)?

Day / Month / Year

121 What is the prognosis of this condition?
Give a timeframe, if applicable.

Treatment

122 What treatment is currently being provided for this condition (e.g. hospitalisation, surgery, medication, counselling, 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).

123 How effective is current treatment?

Describe response to treatment and degree of control of symptoms.

124 Describe any adverse effects of treatment, including severity.

125 What treatment has been undertaken in the past (e.g. hospitalisation, surgery, medication, counselling, 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).

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

No ☐ ▶ *Go to next question*

Yes ☐ ▶ Give details below

127 Is any future treatment planned for this condition?

No ☐ ▶ ***Go to 129***

Yes ☐ ▶ Give details below

128 What is the expected benefit of future treatment?

Detail improvement in symptoms *and* functional capacity.

129 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

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

Functional impact

131 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).

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.

Continued

K Other impacts as applicable.

132 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

133 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 ☐

134 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.

135 Is this condition episodic or fluctuating?

No ☐ *Go to next question*

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

Other information

136 History of this condition.

Provide details of underlying causes and contributing factors.

137 Provide any additional comments about this condition.

PART G – Additional information

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

No ☐ ▶ *Go to next question*

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.

139 Patient's details

Height

Weight

Blood pressure

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

No ☐ ▶ ***Go to 142***

Yes ☐ ▶ Diagnosis of condition

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

No ☐

Yes ☐

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.

142 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

143 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 per-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

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

- No assistance required ☐ ***Go to 146***
- 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

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

Nil ☐ Minimal ☐ Moderate ☐ Substantial ☐

Give details below

PART i – Certification

146 This person has been...

my patient since — Day / Month / Year

a patient at this practice since — Day / Month / Year

147 Further contact–

This information is used for the purpose of assessing income support and suitable assistance that may be provided. Assessors using this information include medical assessors, job capacity assessors, Work and Income psychologists, Disability Officers and Customer Service Officers.

Would you like to discuss any aspects of this report with Work and Income?

No ☐ *Go to next question*

Yes ☐ If someone from Work and Income, or another specialist assessor nominated by Work and Income, needs to contact you to discuss any aspects of this report, what days/times suit you?

Day	Time		
	am pm	to	am pm
	am pm	to	am pm
	am pm	to	am pm

148 Doctor's details and declaration

Please make sure you have read the **Privacy and your personal information** on **page 2** of this form.

Please print in BLOCK LETTERS or use stamp.

Details of doctor completing this report:

Name of doctor

Qualifications

Address

Country Postcode

Phone number — Country ( ) Area code ( )

Signature — On completion of this form, print and sign by hand

Date — Day / Month / Year

Stamp (if applicable) — On completion of this form, print and use your stamp here

149 Returning this report

Please post this completed report and any attachments directly to Work and Income, or if you prefer, you may give this completed report and any attachments to your patient to return to Work and Income.

Thank you for your assistance.

Return address
Work and Income **International Services** **PO Box 27 178** **Wellington** **NEW ZEALAND**

Print Clear