Australian Government
Department of Human Services

centrelink

# Medical Report
for Assessor

**Customer's details**

Full name

Address

Postcode

Date of birth / /

Centrelink Reference Number (CRN) – – –

Home phone number ( )

Mobile phone number

Email address @

**To be completed by the Assessor issuing the Medical Report**

Full name

Organisation

Date / /

## Information for the customer and the doctor

This Medical Report has been issued by an Assessor so that they can gather additional medical information.

The Medical Report must be fully completed by a treating doctor or specialist. This information will help the Australian Government Department of Human Services in determining:

- income support eligibility
- if the customer may benefit from a program of support, for example rehabilitation or training
- if the customer is eligible to enter the Supported Wage System.

## Instructions for the customer

Please use these instructions in order to return the completed Medical Report form.

1. **Make sure your details are completed (above).**

2. **Contact your doctor and make an appointment to have the Medical Report completed.**

   Make sure the doctor and their receptionist know that you will need this report completed, as a long consultation may be required. If your doctor does not Bulk Bill, your consultation fee may be more than usual because of the extra time taken to complete the report.

3. **Attend the appointment with your doctor.**

4. **When your doctor has completed the Medical Report, it must be returned to us.**

   If you have any questions about this report, call us on **132 717**.

*Continued*

## Information for the doctor

**Completing this report**

In this report you will be asked to provide information about your patient's medical condition(s). Please complete all the required questions in this report.

If you require another copy of the Medical Report, go to our website **humanservices.gov.au/medicalreport**

If you need more information in order to complete the Medical Report call us on **132 150**.

**Returning this report to Human Services**

You can give this report and any attachments to your patient or you can return this report directly to us. When returning the form to us, please use the address provided on page 9 of this form.

*Continued*

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## Instructions for the customer – *continued*

**Important** – This request is a notice given under section 63 of the *Social Security (Administration) Act 1999*.

### IMPORTANT INFORMATION

**Privacy and your personal information**

Centrelink, Medicare Australia, Child Support and CRS Australia are services within the Australian Government Department of Human Services (Human Services).

Your personal information is protected by law, including the *Privacy Act 1988*. Your information is collected for Social Security, Family Assistance, Medicare, Child Support and CRS purposes. This information may be required by the powers provided within each services' legislation or voluntarily given by you when you apply for services or payments.

Your information will be used for the assessment and administration of payments and services. Your information may also be used within Human Services, where you have provided consent or it is required or authorised by law. Human Services may disclose your information to Commonwealth departments, other persons, bodies or agencies ONLY where you have provided consent or it is required or authorised by law.

You can get more information about privacy by going to our website **humanservices.gov.au/privacy** or requesting a copy of the full privacy policy at one of our Service Centres.

## Information for the doctor – *continued*

**Request for clarification of additional information**

Human Services, including staff from the Health Professional Advisory Unit, may make contact with you to discuss the information in your report. These contacts will only occur where information requires clarification.

**Reimbursement for services**

We have asked your patient to let you (and your receptionist) know at the time of making their appointment that they require you to complete this report. This is to ensure that you have sufficient time for the examination and completion of the report. The time taken to complete this report counts towards the length of the consultation. You can claim it as a long consultation.

**For information about confidentiality and disclosure of information**

See questions 9 and 12.

**Thank you for your assistance.**

**Please use black or blue pen.**

**1** This person has been: my patient since / /

a patient at this practice since / /

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

No ☐ ▶ ***You do not need to complete question 3. Go to 4***

Yes ☐ ▶ Diagnosis

▶ *Go to next question*

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

No ☐ ▶ *Go to next question*

Yes ☐ ▶ ***You do not need to complete questions 4 to 8. Go to 9***

**4** Does the patient have one or more medical conditions that have a **significant impact** on their ability to function (e.g. endurance, walking, sitting, standing, performing daily activities, handling and manipulating objects, bending, self-care, concentration, attention, communication, hearing, vision, continence, consciousness)?

No ☐ ▶ ***You do not need to complete question 5. Go to 6***

Yes ☐ ▶ *Go to next question*

**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.

(see next page)

## Condition 1—*condition with most impact*

### Diagnosis

**A Diagnosis**

Date of onset (if known) / /

The diagnosis is:

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

No ☐

Yes ☐

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

No ☐

Yes ☐ ▶ Give details below

Psychiatrist/ Clinical Psychologist ☐ ▶ Name

Audiologist/Ear, Nose and Throat specialist ☐ ▶ Name

Ophthalmologist ☐ ▶ Name

Other ☐ ▶ Name and specialty

Are the relevant specialist reports available?

No ☐

Yes ☐ ▶ Attached ☐

Will provide on request ☐

Date of diagnosis / /

### Treatment

**B Current treatment**

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

| Treatment | Date commenced |
|---|---|
| | / / |
| | / / |
| | / / |
| | / / |
| | / / |
| | / / |
| | / / |

## Condition 1—*continued*

### Treatment—*continued*

**C Past treatment**

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

| Treatment type | Date commenced | 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 |
|---|---|---|
| | | / / |
| | | / / |
| | | / / |
| | | / / |

**E Future/planned treatment**

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

**F Patient's compliance with recommended treatment**

Very compliant ☐ Usually compliant ☐ Rarely compliant ☐ Uncertain ☐

Detail any issues related to accessing or undertaking suitable treatment that affect the level of compliance.

### Clinical features

**G Current symptoms**

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

## Condition 1—*continued*

### Clinical features—*continued*

**H History**

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

### Impact on ability to function

**I Details about how this condition and its treatment currently impact on the patient's ability to function**

Be specific and consider the impacts on:

- endurance
- movement/dexterity (e.g. walking, bending, sitting, standing, lifting/carrying/manipulating objects)
- neurological/cognitive function (e.g. concentrating, decision making, memory, problem solving)
- functions of consciousness (details of involuntary loss of consciousness or altered consciousness (e.g. seizures, migraines)
- behaviour, planning, interpersonal relationships
- sensory function (e.g. seeing, hearing, speaking)
- digestive, reproductive, continence function
- need for care (e.g. support in daily living, support accommodation or nursing home/hospital care).

**J 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 ☐

**K Within the next 2 years the effect of this condition on the patient's ability to function is expected to:**

Resolve ☐ Significantly improve ☐ Slightly improve ☐ Fluctuate ☐

Remain unchanged ☐ Deteriorate ☐ Uncertain ☐

Provide details

**For a second condition that has a significant impact on ability to function, go to Condition 2, on the next page.**
**If there are no other conditions that have a significant impact on ability to function, go to question 6 on page 10.**

## Condition 2

### Diagnosis

**A Diagnosis**

Date of onset (if known) / /

The diagnosis is:

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

No ☐

Yes ☐

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

No ☐

Yes ☐ ▶ Give details below

Psychiatrist/ Clinical Psychologist ☐ ▶ Name

Audiologist/Ear, Nose and Throat specialist ☐ ▶ Name

Ophthalmologist ☐ ▶ Name

Other ☐ ▶ Name and specialty

Are the relevant specialist reports available?

No ☐

Yes ☐ ▶ Attached ☐

Will provide on request ☐

Date of diagnosis / /

### Treatment

**B Current treatment**

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

| Treatment | Date commenced |
|---|---|
| | / / |
| | / / |
| | / / |
| | / / |
| | / / |
| | / / |
| | / / |

## Condition 2—*continued*

### Treatment—*continued*

**C Past treatment**

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

| Treatment type | Date commenced | 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 |
|---|---|---|
| | | / / |
| | | / / |
| | | / / |
| | | / / |

**E Future/planned treatment**

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

**F Patient's compliance with recommended treatment**

Very compliant ☐ Usually compliant ☐ Rarely compliant ☐ Uncertain ☐

Detail any issues related to accessing or undertaking suitable treatment that affect the level of compliance.

### Clinical features

**G Current symptoms**

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

## Condition 2—*continued*

### Clinical features—*continued*

**H History**

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

### Impact on ability to function

**I Details about how this condition and its treatment currently impact on the patient's ability to function**

Be specific and consider the impacts on:

- endurance
- movement/dexterity (e.g. walking, bending, sitting, standing, lifting/carrying/manipulating objects)
- neurological/cognitive function (e.g. concentrating, decision making, memory, problem solving)
- functions of consciousness (details of involuntary loss of consciousness or altered consciousness (e.g. seizures, migraines)
- behaviour, planning, interpersonal relationships
- sensory function (e.g. seeing, hearing, speaking)
- digestive, reproductive, continence function
- need for care (e.g. support in daily living, support accommodation or nursing home/hospital care).

**J 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 ☐

**K Within the next 2 years the effect of this condition on the patient's ability to function is expected to:**

Resolve ☐ Significantly improve ☐ Slightly improve ☐ Fluctuate ☐

Remain unchanged ☐ Deteriorate ☐ Uncertain ☐

Provide details

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

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

No ☐ *Go to next question*

Yes ☐ Give details below

**7** Is there any other information that you would like to provide?

No ☐ *Go to next question*

Yes ☐ Give details below

**8** Do you wish to provide medical certificate details on this report?

No ☐ *Go to next question*

Yes ☐ **Certification**

I examined this person on / /

In my opinion this person is temporarily unfit for work or study from / / to / /

In my opinion this person can ☐ cannot ☐ currently do their usual work or study or any other work for 8 hours or more per week.

**9** **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 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 the patient. Similarly, please 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 his/her 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.

**Once completed, please return this report directly to Disability Services, Reply Paid 7806, CANBERRA BC ACT 2610.**

*Continued*

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

No ☐

Yes ☐ Int

**11** If someone from Human Services, or another assessor nominated by us, 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 | |

**12** **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*.

**13** Details of doctor completing this report

Please print in BLOCK LETTERS or use a stamp.

Name

Professional qualifications

Address

Postcode

Phone number

( )

Signature

Date

/ /

Stamp (if applicable)

## Returning this report

**You can give this report and any attachments to your patient or you can return this report directly to us. However, if you answered 'Yes' at question 9, please make sure to return this report directly to Disability Services, Reply Paid 7806, CANBERRA BC ACT 2610.**