

### Customer's details

Full name

Address

Date of birth

Your Centrelink Reference Number

Phone number

### 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 assistance or training
- if the customer is eligible to enter the Supported Wage System.

### Instructions for the customer

- 1 Complete your details above.**
- 2 Contact your doctor or medical specialist 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.

**Important information:** A doctor or medical specialist is a person registered and licensed under a state or territory law that provides for the registration or licensing of medical practitioners. It includes only those with recognised medical qualifications such as general practitioners and medical specialists and excludes those with non-medical qualifications (e.g. psychologists or physiotherapists).

**Note:** If a person has an intellectual impairment and this is their only condition, the Medical Report can be completed by the person's treating psychologist).
- 3 Attend the appointment with your doctor or medical specialist.**
- 4 When your doctor or specialist has completed this Medical Report, it must be returned to us.**
- 5 If you have other relevant information such as specialist medical reports or an assessment of your intellectual function showing your IQ score (if relevant to your claim), return them to us with this report.**

Continued

### Information for the doctor

#### Completing this report

You can complete and lodge Medical Reports electronically through Health Professional Online Services (HPOS). For more information go to our website [humanservices.gov.au/healthprofessionals](http://humanservices.gov.au/healthprofessionals) and logon to HPOS.

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 paper copy of the Medical Report, go to our website [humanservices.gov.au/forms](http://humanservices.gov.au/forms)

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

#### Returning this report

You can give this report and any attachments to your patient or you can return it to

**Department of Human Services  
Disability Services  
Reply Paid 7806  
CANBERRA BC ACT 2610**

Continued



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## Instructions for the customer

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

### Privacy and your personal information

Your personal information is protected by law, including the *Privacy Act 1988*, and is collected by the Australian Government Department of Human Services for the assessment and administration of payments and services. This information is required to process your application or claim.

Your information may be used by the department or given to other parties for the purposes of research, investigation or where you have agreed or it is required or authorised by law.

Where necessary Human Services or your assessor may contact your doctor(s) and other treating providers to clarify information provided about your medical conditions.

You can get more information about the way in which the Department of Human Services will manage your personal information, including our privacy policy at

**[humanservices.gov.au/privacy](https://humanservices.gov.au/privacy)** or by requesting a copy from the department.

## Information for the doctor

### 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

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▶ *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.

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

## Condition 1—condition with most impact

### Diagnosis

#### A Diagnosis

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Date of onset (if known)

/ /
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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

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Audiologist/Ear, Nose  
and Throat specialist  Name

--

Ophthalmologist  Name

--

Other  Name and specialty

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Are the relevant specialist reports available?

No

Yes  Attached

Will provide on request

Date of diagnosis

/ /
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### 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**

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     3–12 months     13–24 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)

/	/
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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

/	/
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### 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

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     3–12 months     13–24 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 <input type="text" value="/ /"/>
In my opinion this person is temporarily unfit for work or study from <input type="text" value="/ /"/> to <input type="text" value="/ /"/>
In my opinion this person can <input type="checkbox"/> cannot <input type="checkbox"/> 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 Department of Human Services, Disability Services, Reply Paid 7806, CANBERRA BC ACT 2610.**

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

No

Yes  Int

*Continued*

- 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	To
<input type="text"/>	<input type="text"/> : <input type="text"/> am <input type="text"/> pm	<input type="text"/> : <input type="text"/> am <input type="text"/> pm
<input type="text"/>	<input type="text"/> : <input type="text"/> am <input type="text"/> pm	<input type="text"/> : <input type="text"/> am <input type="text"/> 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 **IMPORTANT INFORMATION FOR THE DOCTOR OR MEDICAL SPECIALIST – Privacy and your personal information**
- Your personal information is protected by law, including the *Privacy Act 1988*, and is collected by the Australian Government Department of Human Services for the assessment and administration of payments and services.
- Your information may be used by the department or given to other parties for the purposes of research, investigation or where you have agreed or it is required or authorised by law.
- You can get more information about the way in which the Department of Human Services will manage your personal information, including our privacy policy at [humanservices.gov.au/privacy](http://humanservices.gov.au/privacy) or by requesting a copy from the department.

- 14 Details of doctor completing this report  
Please print in BLOCK LETTERS or use a stamp.

Name

Professional qualifications

Address

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

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 Department of Human Services, Disability Services, Reply Paid 7806, CANBERRA BC ACT 2610.