

# Medical Statement

To be completed by a registered medical practitioner. The patient will incur any charge for this service.

Mark boxes with  where appropriate, otherwise use block letters. Leave a box between words.



## Patient/claimant details

Title  Surname

Given names

Address

Suburb  State  Postcode

Occupation/Profession  Date of birth  /  /

## Patient history

1 Are you the patient's usual doctor? Yes  No

If 'YES', how long have you known the patient?

2 When did the patient first consult you for the present condition?  /  /

3 When did the present condition commence?  /  /

4 When would the condition have caused the patient to cease work?  /  /

5 Please provide a summary of the patient's present condition including cause, symptoms and diagnosis:

6 Please detail a history of this condition, including all dates of consultation: (attach separate list if required)

Date of consultation	Reasons, including symptoms, diagnosis and test results	Treatment prescribed	Results	Progress of patient's condition (recovered, improved, static, deteriorated)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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## Patient history (continued)

- 7 Does the patient have a prior medical history related to the present condition?  
If 'YES', please provide details:

Yes  No


- 8 Please provide details of other persons the patient has consulted for this condition:

Name	Address and phone number	Qualifications	Date(s) consulted

## Medical certification

Please complete either:

**Section 1.** If patient was unable to work; or

**Section 2.** If patient was able to work on a partial/restricted basis; or

**Section 3.** If patient has recovered



### Section 1. Inability to work

- i. What period was the patient unable to perform any of the duties of his/her occupation?

Period from  /  /  to  /  /

- i. What are the patient's capabilities and limitations with respect to the above period?

Capabilities

Limitations

- iii. When do you consider that the patient may return to work on a partial/restricted or full-time basis?

Date

Basis of return to work

/  /



## Your details (please print)

Title	Surname		
<input type="text"/>	<input type="text"/>		
Given names			
<input type="text"/>			
Address			
<input type="text"/>			
Suburb	State	Postcode	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Phone No.	Qualifications		
<input type="text"/>	<input type="text"/>		
Signature of Medical Practitioner	Date		
<input type="text"/>	<input type="text"/>		



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