

To be completed by the attending medical practitioner.

Important: Please make sure you've answered all questions.  
Use BLOCK letters and dark ink when completing this form and ensure it's signed and dated.

Please read the below prior to completing this statement.

The patient has applied to their superannuation fund (HESTA) for payment of an insurance benefit.  
From your professional association with the below-mentioned patient, please complete in detail the following questions in relation to any illness or medical impairment, which in your opinion might affect his/her functional capacity.

Medical Attendant's Statement

1. What is the patient's name and date of birth?

Name:

Date of birth (dd/mm/yyyy):

2. How long have you known the patient and how long have they attended your practice?

Known patient:

 years  months

Attended practice:

 years  months

3. What is the primary condition?

Primary condition details:

Primary condition date of diagnosis (dd/mm/yyyy):

What is the nature and severity of the symptoms your patient is currently reporting for the primary condition?

Symptoms:

Severity:

When did these symptoms first arise for the primary condition? Date (dd/mm/yyyy):

4. Secondary condition details and any additional medical conditions (if applicable):

Secondary condition date of diagnosis (if applicable) (dd/mm/yyyy):

/ /

What is the nature and severity of the symptoms your patient is currently reporting for the secondary condition (if applicable)?  
Symptoms:

Severity:

When did these symptoms first arise for the secondary condition? (If applicable) Date (dd/mm/yyyy):

/ /

5. What is the long term/short term prognosis for the secondary condition (if applicable)?

Long term prognosis:

Short term prognosis:

6. If illness, is your patient considered terminal? ☐ No ☐ Yes

If 'Yes', what is the life expectancy?

7. Have you provided any medical certificates for your patient? ☐ No ☐ Yes

If 'Yes', please provide copies of all medical certificates.

8. Has the patient ever suffered a similar or the same condition in the past? ☐ No ☐ Yes

9. What was the first/last consultation date and frequency of consultations with respect to the claimed condition?

First consult date:

/ /

Last consult date:

/ /

Frequency of consults (weekly, fortnightly, monthly/or as needed):

10. On what consultation date(s) did you first note that the patient was not capable of performing (a) all and/or (b) some of their duties?

(a) All of their duties (dd/mm/yyyy)

/ /

(b) Some of their duties (dd/mm/yyyy)

/ /

11. Please provide details as listed below for investigations, treatments, and medications:

Investigations, treatments, and medications (including dosages) undertaken to date:

Investigations, treatments, and medications (including dosages) planned for the future:

12. Please provide details of hospitalisations and/or surgical interventions:

13. Please provide details of any rehabilitation that has been undertaken by, or is planned or otherwise suitable for the patient to assist with their recovery and return to work:

14. What do you understand to be the patient's important/major duties they undertake?  
(Major involves at least 20% of his/her overall occupational tasks):

**Please complete this section if the patient is suffering from a physical condition. If it is a psychological condition, please go to the psychological function section. If both apply, please complete both functional sections.**

15. Please detail the patient's functional ability below. Please consider **ALL** functions and not only those related to the patient's occupation:

Physical function

Maximum functional ability

Sitting	<input type="checkbox"/> Over 2 hours <i>Unrestricted with usual breaks</i>	<input type="checkbox"/> 2 hours <i>Able to sit for a dinner at a restaurant or to watch a full-length movie</i>	<input type="checkbox"/> 60 minutes <i>Able to watch the nightly TV news or one half of a sporting match on TV</i>	<input type="checkbox"/> 30 minutes <i>Able to sit as passenger for a 15km car trip with traffic</i>	<input type="checkbox"/> 10 minutes <i>Need to stand and change posture each advert break when watching TV</i>	<input type="checkbox"/> Nil <i>Unable to sit</i>
	Is this a current requirement of their role? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure					
	Additional comments:					

**Physical  
function**
**Maximum functional ability**

Standing	<input type="checkbox"/> Over 2 hours <i>Unrestricted with usual breaks</i>	<input type="checkbox"/> 2 hours <i>Able to stand to watch a music concert</i>	<input type="checkbox"/> 60 minutes <i>Able to stand to watch a sporting match</i>	<input type="checkbox"/> 30 minutes <i>Able to stand in the kitchen to prepare a meal</i>	<input type="checkbox"/> 10 minutes <i>Unable to stand to wait for a bus or train or wash up dishes in a sink</i>	<input type="checkbox"/> Nil <i>Unable to stand</i>
	Is this a current requirement of their role? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure					
	Additional comments:					
Walking	<input type="checkbox"/> Over 2 hours <i>Unrestricted with usual breaks</i>	<input type="checkbox"/> 2 hours <i>Able to walk around a shopping mall, visiting various shops</i>	<input type="checkbox"/> 60 minutes <i>Able to walk around an art gallery or museum</i>	<input type="checkbox"/> 30 minutes <i>Able to walk around a supermarket to perform a weekly shop</i>	<input type="checkbox"/> 10 minutes <i>Unable to walk around two standard blocks (600 m)</i>	<input type="checkbox"/> Nil <i>Unable to walk</i>
	Is this a current requirement of their role? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure					
	Additional comments (including whether the patient can walk on uneven surfaces):					
Lifting	<input type="checkbox"/> 18–25 kg <i>Able to lift a bag of cement</i>	<input type="checkbox"/> 13–17 kg <i>Able to lift an 18-month-old child</i>	<input type="checkbox"/> 8–12 kg <i>Able to lift a vacuum cleaner or one case of 24 cans of drink</i>	<input type="checkbox"/> 4–7 kg <i>Able to carry a full (dry) washing basket, or 2–3 shopping bags</i>	<input type="checkbox"/> 1–3 kg <i>Unable to lift a laptop computer</i>	<input type="checkbox"/> Nil <i>Unable to lift a 1 L milk or soft drink bottle (1 kg)</i>
	Is this a current requirement of their role? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure					
	Additional comments:					
Driving	<input type="checkbox"/> Over 2 hours <i>Unrestricted with usual breaks</i>	<input type="checkbox"/> 2 hours <i>Able to drive long freeway distances with appropriate safety breaks</i>	<input type="checkbox"/> 60 minutes <i>Able to drive for 30 km, across city suburbs or between country towns</i>	<input type="checkbox"/> 30 minutes <i>Able to drive for 15 km car trip with traffic</i>	<input type="checkbox"/> 10 minutes <i>Unable to drive to local shops or local school run</i>	<input type="checkbox"/> Nil <i>Unable to drive</i>
	Is this a current requirement of their role? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure					
	Additional comments:					

**Ability**
**Functional ability**
**Comments:** (e.g. frequency in work day, expected duration of temporary work restriction with usual posture breaks)

Pushing/ Pulling	<input type="text"/> kg	
Reaching above shoulders	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Bending from waist	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**Ability**      **Functional ability**      **Comments:** (e.g. frequency in work day, expected duration of temporary work restriction with usual posture breaks)

Kneeling	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Squatting	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Climbing stairs	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Typing	<input type="text"/> Hours <input type="text"/> Minutes	

*Please complete the following section if the patient has a psychological condition.*

**Psychological function**      **Is this psychological function impacted by the patient's condition(s)?**      If 'Yes', please describe the impact.

Concentration	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Memory	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Energy	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Sleep	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Social interaction	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Motivation	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Panic attacks	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Mood	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Self-care	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Leaving the house	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**Psychological function**      **Is this psychological function impacted by the patient's condition(s)?**      **If 'Yes', please describe the impact.**

Emotional control/ self-regulation	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Stress management	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Please provide details of any other functional restrictions or considerations not reflected above (if appropriate):

16. Are any of these functional restrictions considered permanent?    ☐ No    ☐ Yes

If 'Yes', please provide further details:

17. Has the patient returned to work in any capacity?    ☐ No    ☐ Yes

If 'No', in your opinion, when will they potentially be able to perform:

(i) Some duties of their occupation (dd/mm/yyyy)?

/ /

AND/OR

(ii) All duties of their occupation (dd/mm/yyyy)?

/ /

OR

(iii) ☐ Unsure/Unknown

OR

(iv) ☐ The patient will not be able to perform the duties of their occupation in the future.

If (iv) is selected, please provide further information below:

Why won't the patient be able to perform some or all of the duties of their usual occupation?

Will the patient be able to perform any work or duties within their education and/or training or experience in the future?  
Please provide rationale for response.

If 'Yes', please answer the relevant following questions:

(i) On what date did they return (dd/mm/yyyy)?

/ /

(ii) In what capacity have they returned to work (full hours and duties or partial return)?

(iii) Please explain the nature of any return-to-work modifications and plans for future increases in hours or duties if known (as applicable):

18. Other than the medical factors, are there any psychosocial and environmental barriers impacting the patient's ability to recover?

19. Does the patient have any other claims regarding this disability including but not limited to: Workers' Compensation, other insurance claims, disability support pension, etc?

☐ No ☐ Yes

If 'Yes', please provide details including provider and claim number, if applicable:

20. Are there any additional comments or remarks that you would like to make?

**Please include any supplementary reports (including Mini Mental Health Exams, if possible), diagnostics and certifications relevant to the claim condition.**

## Declaration

Your name:

Provider number:

Professional qualification:

Phone number:

Specialty:

Fax number:

Email:

Practice/Hospital name:

Practice/Hospital street address/PO Box:

Postcode:

I hereby certify that I have examined the patient and all responses made in this statement are correct in all aspects. I consent to the superannuation fund and its insurer providing copies of this statement to any medical specialist from whom the insurer seeks an independent report or to any other person deemed necessary to assist in the assessment of the patient's claim.

Signature:

Date: (dd/mm/yyyy)