

GUIDE TO COMPLETION OF INITIAL MEDICAL REPORT

- This form is for completion by the treating medical practitioner of the person who is making the claim.
 - Please answer all questions fully - this will avoid any undue delays to your patient.
 - Your patient is responsible for meeting payment of any fees for the completion of this form.
 - If you have any suggestions you think we can help with returning your patient to work, please let us know in the "additional comments" section of the form.
 - If you think we can assist you or your patient with respect to this claim, we would welcome your comments
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INITIAL MEDICAL REPORT FORM

1. Surname of Person Claiming _____ First Name _____
2. Date of Birth _____
3. Occupation/duties _____
4. Are you the claimant's usual medical attendant? Yes No If Yes, please advise the length of time the claimant has been consulting you. _____
5. Is the disability as the result of an accident or as the result of an illness? _____
6. If the disability is the result of an accident, how did the accident occur? _____

7. If the disability is the result of an accident, on what date did the accident happen? _____
8. If the disability is the result of an illness, on what date did the symptoms first present themselves and what were they? _____
9. On what date did you first consult the claimant in regard to this illness or injury? _____
10. Has the claimant seen any other doctor, in relation to this disability, prior to seeing you? _____
If so, please advise the name and address of that doctor _____
11. When was the last time you consulted the claimant in regard to this illness or injury? _____
12. When are you next scheduled to consult the claimant in regard to this illness or injury? _____
13. Please provide your full diagnosis _____
14. How does the illness or injury actually prevent, or restrict, the claimant from working? _____

15. Have you conducted any tests to confirm your diagnosis? Yes No If Yes, please advise the nature, date and the result of the tests _____
16. What is the nature of any treatment, including surgery, or medication being prescribed, if any?

17. Please provide the name and contact details of any specialist to whom the patient has been referred and the advice given by the specialist _____

18. Are you intending to refer the claimant to a specialist? Yes No If Yes, when and which specialty? _____
19. If hospitalisation was necessary please advise the date of :-
Admission _____ Discharge _____
20. Prior to this current condition has the claimant had any other health problem? Yes No
If Yes, please provide dates and details _____

21. In respect of the claimant's present disability, have you given any certificate or report to another Insurance Company, Workers Compensation Insurer, Social Security Office, Third party Insurer, Solicitor or the claimants employer? Yes No If Yes, please advise to whom reports have been sent

22. If the claimant is currently totally disabled from performing the duties of their usual occupation, please state from what date _____
23. If the claimant is currently **partially** disabled from performing the duties of their usual occupation, please state from what date _____
24. If the claimant is currently **partially** disabled from performing the duties of their usual occupation, please advise what duties of their usual occupation they **are** capable of performing?

25. If the claimant is partially disabled and able to perform **all** the duties of their usual occupation at a reduced capacity, please advise the percentage of time lost (ie half days = 50%). _____
26. On what date was the claimant able to resume work? _____
27. If the claimant has not yet resumed work, when do you anticipate he/she will be able to?
Part time _____ Full time _____

Additional Comments

TOWER has obtained our customer's consent for you to collect and disclose their personal and sensitive information. A copy of the consent to disclose is attached. We require you to comply with the Privacy legislation with respect to our customer's personal and sensitive information.

Signature _____ Date _____

Name _____

Qualifications _____

Address _____

Postcode _____



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