



Australian Government

Department of Veterans' Affairs

Medical Report - Injury to the Knee Chondromalacia Patella

The information you provide on this form will assist in deciding eligibility for benefits under the Veterans' Entitlements Act 1986 and/or Military Rehabilitation and Compensation Act 2004. In the event of an appeal against a decision, this information may be provided to the Veterans' Review Board, Administrative Appeals Tribunal or Federal Court.

Veteran's Details

Surname

Given Names

DVA File Number

Report Detail

A claim for service related compensation in respect of the above named leads the Department to consider whether an injury to the knee could be relevant to the development of (_____) in this case. Would you please answer the following questions:

1. When was the clinical onset of chondromalacia patella?

☐ **Left**/...../.....

☐ **Right**/...../.....

2. Has the veteran ever suffered:

* direct trauma to the patella of either knee? (*This has been defined by the Repatriation Medical Authority as a blow to the kneecap causing immediate patellar pain that persists for at least 24 hours*); or

* an injury to either knee resulting in acute meniscal tear or permanent ligamentous instability?

☐ **No** - Please sign the form and return it to the Department

☐ **Yes** – For **each incident** suffered please provide information overleaf (attach a separate sheet if necessary):

Date:	
Knee involved (left or right):	
Description of: <ul style="list-style-type: none"> • injury sustained • symptoms suffered 	
Description of how the injury occurred: <i>(If the injury occurred as a consequence of another medical condition eg a fall because of a TIA, please identify the medical condition)</i>	
Details of treatment received:	

3. Did the chondromalacia patella permanently worsen? **Note:** For the purposes of the *Veterans' Entitlements Act* (1986), permanent worsening requires an increase in the gravity of the disease beyond its natural progression. It excludes temporary exacerbations or any deterioration which is part of the normal course of the disease.

- ☐ **No** – Please sign the form and return it to the Department
- ☐ **Yes** – Please describe when this occurred, including a date:

<input type="checkbox"/> Left/...../.....
<input type="checkbox"/> Right/...../.....

Details of Medical Practitioner providing advice:

Stamp

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Signature

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