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Medical Report - Injury to the Shoulder

Rotator Cuff Syndrome

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** |
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Report Detail

A claim for service related compensation in respect of the above named leads the Department to consider whether an injury to the shoulder could be relevant to the causation (or aggravation of pre-existing) rotator cuff syndrome in this case. Would you please answer the following questions:

1. When was the clinical onset of rotator cuff syndrome?

 Left ………./………./………

 Right ………./………./………

2. Have you been involved in the treatment of any shoulder injury implicated in the development or progression of rotator cuff syndrome?

 **No** *– Please sign the form and return it to the department.*

 **Yes** – Pleaseprovide the date of the injury and describe how it happened.*[If the injury occurred as a consequence of another medical condition, eg a fall because of a TIA, please identify the other medical condition]*

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3. Please describe the symptoms of this shoulder injury, including the duration of symptoms.

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4. Please provide details of any medical treatment received following this injury:

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{If worsening}

5. Did the underlying pathology of rotator cuff syndrome 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 -** *When did this occur and what do you believe to have been the cause of the worsening?*

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| ………./………./………. |
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{EndIf worsening}

Details of Medical Practitioner providing advice:

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| --- | --- | --- |
| **Stamp** |  |  |
|  |  |  |
|  |  | **Signature** |
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