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Medical Report - Acute Viral Infection

Sensorineural Hearing Loss

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 acute viral infection could be relevant to the development of sensorineural hearing loss in this case. Would you please answer the following questions:

1. When was the clinical onset of sensorineural hearing loss?

 Left ………./………./……….

* Right ………./………./……….

2. Please forward a copy of the most recent audiogram you have.

3. Did the veteran suffer an acute infection with any of the viruses specified?

 **Yes -** *please indicate which virus was suffered:*

 **Mumps**  **Pertussis**

 **Measles**  **Varicella-zoster**

 **Rubella**

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

4. Please provide details of the viral infection:

|  |  |  |
| --- | --- | --- |
| ***Viral infection*** | ***Date acute infection started*** | ***Date infection cleared*** |
|  |  |  |
|  |  |  |
|  |  |  |

{If worsening}

5. Did the sensorineural hearing loss permanently worsen? **Note:** For the purposes of the *Veterans’ Entitlement 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**

 **Yes** – Please provide details, including date of worsening

|  |
| --- |
|  Left ………./………./………. |
| * Right

………./………./………. |

{EndIf worsening}

Details of Medical Practitioner providing advice:

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