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Medical Report - An Episode of Severe Diarrhoea

Irritable Bowel 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** | |
|  |  | |  | |  | |  | |

Report Detail

A claim for service related compensation in respect of the above named leads the Department to consider whether an episode of severe diarrhoea could be relevant to the development of irritable bowel syndrome in this case. Would you please answer the following questions:

1. When was the clinical onset of irritable bowel syndrome?………./………./……….

2. Has the veteran suffered from an episode of severe diarrhoea requiring medical attention?

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

 **Yes -** *Please provide the following details for each episode.* ***In particular, could you please indicate whether the diarrhoea was caused by an infective organism, and if so, the name of the organism.***

|  |  |  |
| --- | --- | --- |
| **Dates** | **Details of treatment provided or investigations performed** | **Cause of the diarrhoea - specify the particular infective organism, if appropriate** |
| **/ / to / /** |  |  |
| **/ / to / /** |  |  |
| **/ / to / /** |  |  |

3. Would you care to make any other comments about the veteran's irritable bowel syndrome?

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4. Did the irritable bowel 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**

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

|  |
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|  |
| ………./………./………. |

Details of Medical Practitioner providing advice:

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