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Medical Report - Aspirin

Cerebrovascular Accident

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 aspirin could be relevant to the development of (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) in this case. Would you please answer the following questions:

1. When was the clinical onset of (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)?………./………./……….

2. Had the veteran been taking aspirin within the seven days before the onset of (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)?

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

 **Yes**

3. Please provide the following details regarding any aspirin ingestion that occurred in the **five weeks immediately before the clinical onset of** (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_).

|  |  |  |
| --- | --- | --- |
| **Period of Aspirin Ingestion** | **On how many days per week was aspirin taken** | **Condition for which aspirin was taken** |
|  **/ / to / /**  |  |  |
|  **/ / to / /**  |  |  |
|  **/ / to / /**  |  |  |

Details of Medical Practitioner providing advice:

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