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Medical Report - Alcohol Consumption

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 has been lodged concerning the above named veteran. The Department must consider whether alcohol consumption 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. Is there a history of alcohol abuse or dependence?

 **No** - *Please go to the next question*

 **Yes** - Please provide details:

|  |  |  |
| --- | --- | --- |
| **Date of onset of alcohol abuse or dependence** | **Date of remission (if appropriate)** | **Approximate amount of alcohol consumed each week** |
| / / | / / |  |
| / / | / / |  |

3. Is there a history of alcohol consumption as part of a psychiatric condition, eg post traumatic stress disorder?

 **No** - *Please go to the next question*

 **Yes** - Please provide details:

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of psychiatric condition** | **Date of onset of alcohol consumption as a result of this psychiatric condition** | **Date of cessation of alcohol consumption (if appropriate)** | **Approximate amount of alcohol consumed each week** |
|  | / / | / / |  |
|  | / / | / / |  |
|  | / / | / / |  |

4. Is there a history of using alcohol as “self medication” for a medical condition eg to relieve chronic back pain?

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

 **Yes** - Please provide details:

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of medical condition** | **Date of onset of alcohol consumption as a result of this medical condition** | **Date of cessation of alcohol consumption (if appropriate)** | **Approximate amount of alcohol consumed each week** |
|  | / / | / / |  |
|  | / / | / / |  |
|  | / / | / / |  |

Details of Medical Practitioner providing advice:

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