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Medical Report – A specified spinal condition

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 abovenamed leads the Department to consider whether a specified spinal condition could be a factor in the development of the claimed condition in this case.

1. Please indicate if the veteran has ever had any of the following spinal conditions:

|  |  |  |  |
| --- | --- | --- | --- |
| **Specified spinal condition** | **Date of onset** | **Part of spine affected** | Diagnosis (if applicable) |
| Scoliosis |  |  |  |
| Spondylolisthesis |  |  |  |
| **Retrospondylolisthesis** |  |  |  |
| A deformity of a vertebra |  |  |  |
| A deformity of a joint of a vertebra |  |  |  |
| **Necrosis of bone** |  |  |  |

If the veteran has not had any of the above conditions, please sign the form and return it to the Department.

1. Please indicate the specified spinal condition/s you have identified and provide an opinion about the underlying cause.

|  |  |
| --- | --- |
| **Identified spinal condition (diagnosis)** | **Underlying cause of the condition** |
|  |  |
|  |  |
|  |  |

{If worsening}

**In this case, the veteran has indicated that the claimed condition may have worsened at some stage.**

1. Did the veteran’s claimed condition 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 that is part of the normal course of the disease.

 **No**

 **Yes** – Please provide full details, including date of worsening as described above.

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| ………./………./………. |

{EndIf worsening}

Details of Medical Practitioner providing advice:

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