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Medical Report - A Systemic Arthritic Disease

Plantar Fasciitis

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 a systemic arthritic disease could be relevant to the development of plantar fasciitis in this case. **Note:** The Repatriation Medical Authority (RMA) has defined **a** **systemic arthritic disease** to mean:

*(a) ankylosing spondylitis; or*

*(b) crystal-induced arthropathy; or*

*(c) enteropathic spondyloarthropathy; or*

*(d) psoriatic arthropathy;*

*(e) reactive arthropathy; or*

*(f) undifferentiated spondyloarthropathy*

1. When was the clinical onset of plantar fasciitis?

* Left foot ……/……/……
* Right foot ……/……/……

1. Has the veteran ever suffered from **a** **systemic arthritic disease** as defined by the RMA?

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

 **Yes –** Please provide details below:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Systemic arthritic disease** | **Date of onset** | **Diagnosed condition** | **Treatment and date of remission (if appropriate)** | **Underlying cause (opinion)** |
|  |  |  |  |  |

{If worsening}

3. Did the plantar fasciitis clinically worsen? **Note:** Clinical worsening requires an increase in the gravity of the disease beyond its natural progression.

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

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

 Left foot ……/……/……

 Right foot ……/……/……

{EndIf worsening}

Details of Medical Practitioner providing advice:

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