Treating doctor report

Disablement claim

About this form

Your patient has lodged a total and permanent disablement claim with Equip. Please complete this form as the patient's treating medical practitioner, providing as much information as possible to assist us in the assessment of their claim. If there is insufficient space, please attach additional pages that are clearly marked with the question number reference and ensure you sign and date each page. *Any fee you charge for completion of this report is the responsibility of the patient.*

1 – Patient Personal Details

Title
Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other ☐☐☐

Sex
Male ☐ Female ☐

Date of birth (ddmmyyyy)

Member number

First name

Last name

Patient's occupation

Patient's claimed condition

2 – Your medical practitioner details

Doctor's name

Qualifications

Name of clinic

Address

Suburb

State

Postcode

Country (if not Australia)

Business hours phone

(a) Are you the patient's usual treating medical practitioner? ☐ Yes ☐ No

(b) Are you currently treating the patient? ☐ Yes ☐ No

(c) Date of first consultation (ddmmyyyy) **AND** Date of last consultation (ddmmyyyy)

3 – Medical condition details

(a) Please provide history of all medical condition/s:

Medical condition / diagnosis	Date of injury or onset of symptoms	Date of first consultation	Date diagnosed	Impacts ability to work	Is treatment current / ongoing
	/ /	/ /	/ /	☐ Yes ☐ No	☐ Yes ☐ No
	/ /	/ /	/ /	☐ Yes ☐ No	☐ Yes ☐ No
	/ /	/ /	/ /	☐ Yes ☐ No	☐ Yes ☐ No
	/ /	/ /	/ /	☐ Yes ☐ No	☐ Yes ☐ No

Need help?

Call us on 1800 682 626 or www.equipsuper.com.au Equip, GPO Box 4303, Melbourne VIC 3001

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(b) Please provide details of the symptoms experienced with regards to the condition/s impacting the member's ability to work:

Medical condition	Symptoms reported	Symptoms current

(c) Please provide details of all treatment:

Treatment / Medication	Dated	Is treatment ongoing
	/ /	☐ Yes ☐ No
	/ /	☐ Yes ☐ No

(d) Have you referred the patient to any other doctor/s for an opinion, treatment or investigation? ☐ Yes ☐ No

Name of doctor referred to / specialty	Dated	Did patient attend
	/ /	☐ Yes ☐ No
	/ /	☐ Yes ☐ No

(e) Has hospital admission or surgical treatment been necessary? ☐ Yes - Provide details ☐ No

Name of Hospital / specialty	Admission date	Discharge date
	/ /	/ /
	/ /	/ /

(f) Please attach a copy of all test results or any correspondence form any other medical professional you have received ☐ Attached ☐ No

(g) Is the patient compliant with the recommended treatment? ☐ Yes ☐ No - If no, provide details

(h) Have any improvements in symptoms been achieved through treatment to date? ☐ Yes ☐ No - If no, provide details

(i) Please detail all future treatment planned and the objectives hoped to be achieved

Treatment	Anticipated review date
	/ /
	/ /

(j) Has the patient ever suffered from a similar, related or this condition previously? ☐ Yes ☐ No - If no, provide details

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(k) Please describe the physical limitations and/or restrictions caused by the medical condition

(l) Please describe the psychological limitations and/or restrictions caused by the medical condition

(m) Please describe how theses physical and/or psychological conditions described in both (k) and (l) above affect the patients functional abilities

(n) Are these limitations and/or restrictions permanent? ☐ Yes ☐ No

If **Yes**, from what date did these limitations become permanent? (ddmmyyyy)

If **No**, from what date do you anticipate a recovery? (ddmmyyyy)

4 – Occupational information

(a) What is the patient's usual occupation and regular duties?

(b) What date has the patient reported to you that they ceased all work? (ddmmyyyy)

What was the reason the patient reported to you that they ceased all work?

(c) Can the patient ever return to their usual occupation? ☐ Yes ☐ No

If **Yes**, from what date will the patient be fit to return to work? (ddmmyyyy)

(d) Have you or are you considering implementing a return to work program of any kind? ☐ Yes ☐ No

If **Yes**, please provide details

(e) In your opinion, will the patient ever be able to perform a job for which they are reasonably suited by education, traning and experience? ☐ Yes ☐ No

If **Yes**, please provide example/s of the work the patient is suitable for
If **No**, please provide reasons for your opinion

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(f) Is the patient a suitable candidate for retraining into a new occupation? ☐ Yes ☐ No

Please provide a reason for your answer

(g) Will the patient ever be able to return to any gainful employment? ☐ Yes ☐ No

If **Yes**, please provide example/s of the work options. If **No**, please provide reasons for your opinion

(h) In respect of the patient's condition, have you completed any certificates or reports for any other superfund, insurance company(ies) or in connection with worker's compensation, government departments or any other party (e.g. Centrelink, TAC, Veteran Affairs, Solicitor, Third Party)?

☐ Yes ☐ No If **Yes**, please provide details

Company Name / Department	Reason	Dated
		/ /
		/ /
		/ /

(i) Are there any other comments you would like to make relevant to the patient's condition?

Privacy

The personal information about your patient you provide on this form will be used in accordance with Equip's Privacy Statement, which you can view online at **equipsuper.com.au/privacy** or you can obtain a copy by contacting us on 1800 682 626.

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Equip's Privacy Statement details how we deal with a member's personal information and who they can talk to if they wish to access and seek correction of the information we hold about them. It includes details on how we collect, disclose and manage personal information, including other entities and offshore locations that may receive or provide the information. Our administrator, Mercer Outsourcing (Australia) Pty Ltd, will also handle a member's personal information. You can view Mercer's Privacy Policy online at **mercer.com.au/privacy.html**.

If you have any other queries in relation to privacy issues, you can contact us or write to our Privacy Officer, GPO Box 4303, Melbourne VIC 3001.

Treating doctor's declaration

I certify that I have personally attended the above named patient and that all information provided by me on this form is true, correct and complete. I agree that Togethr Trustees may provide copies of this statement to any medical specialist, or independent specialists or any other person or organisation deemed necessary to assist in the assessment of this claim. I acknowledge my patient's authorisation for me to provide the Trustee with the enclosed information.

First name

Last name

Signature

X

Date (ddmmyyyy)

Please return this form and any attachments to Equip, GPO Box 4303, Melbourne Vic 3001.

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