IMPORTANT

Australian Government
Department of Veterans' Affairs

Injury or disease details sheet

Surname	Given name(s)	DVA file number(s) (if known)

This section to be filled in by the claimant

Please fill out one sheet per injury or disease for which you are now claiming liability at Question 16. **If this is a reassessment, do not complete this sheet**.

Please detail the injury or disease you are now claiming and describe as fully as you can the signs and symptoms that make you notice the disability (e.g. pain in lower back, shortness of breath, loss of range of movement in right arm).

You are requested to ask your doctor to fill in the Medical Practitioner section on the next page before lodging your claim.

Injury or disease

Signs and symptoms

How do you believe your service caused, contributed to or aggravated this injury or disease?

If insufficient space, please attach a separate sheet

When did the injury happen (if applicable)? / /

Has a Defence injury report been completed? No ☐ Yes ☐ Please attach the Defence injury report. Do not know ☐

When did you first notice signs or symptoms of the injury or disease? / /

On what date did you first receive medical treatment for this injury or disease? / / (if known)

Name of your treating medical practitioner/hospital/specialist

For claimed conditions

Type of treatment or consultation provided (e.g. GP, specialist)

Has this injury or disease worsened or been aggravated since 1 July 2004? No ☐ Yes ☐

Is a medical practitioner's account attached in relation to completion of this injury or disease details sheet? No ☐ Yes ☐

Surname	Given name(s)	DVA file number(s) (if known)

This section to be filled in by a medical practitioner

Please supply a brief summary of the basis for each diagnosis and attach any reports you have that confirm the diagnosis. DVA will pay you for this service according to the relevant fee levels for the service.

NOTE: The claim for this condition must be lodged before payment of medical account can be made.

Medical diagnosis

Basis for diagnosis

Is this diagnosis Confirmed ☐ Provisional ☐

When did the claimant first consult you for this injury or disease? / /

Please advise approximate date of onset of the injury or disease based on available notes / /

Address

POSTCODE

Telephone [ ]

Medical practitioner stamp
(Please include Provider Number)

MEDICAL PRACTITIONER'S SIGNATURE

Date / /

Save Print Clear